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Senate

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENTS NOS. 1014, 1015, 1059, 1106, 1086, 1067, 1033, 935, 959, 1038, 1095, EN BLOC

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside and that the following amendments be called up en bloc: No. 1014, by Senator BOND, study of pharmacy services; No. 1015, by Senator DODD, study of blind and disabled; No. 1059, by Senator HATCH, HHS review; No. 1106, by Senator HATCH, citizens councils; No. 1086, by Senator MURKOWSKI, pharmacy access; No. 1067, by Senator LINCOLN, kidney disease; No. 1033, by Senator MIKULSKI, municipal health services; No. 935, by Senator LINCOLN, geriatric GME; No. 959, by Senator LINCOLN, physical therapy demo; No. 1038, by Senator JEFFORDS, critical access hospital; No. 1095, by Senator JOHNSON, therapy management.

I further ask unanimous consent that these amendments be agreed to en bloc and the motion to reconsider be laid upon the table en bloc.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendments were agreed to.

VOTE ON AMENDMENT NO. 1011

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to the Sessions amendment No. 1011.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the following two votes be 10-minute votes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER (Mr. CORNYN). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 33, nays 65, as follows:

[Rollcall Vote No. 256 Leg.]

YEAS—33

Allard	Dole	Lott
Allen	Ensign	McConnell
Bennett	Enzi	Murkowski
Bunning	Frist	Nickles
Burns	Graham (SC)	Santorum
Byrd	Gregg	Sessions
Campbell	Hagel	Shelby
Chambliss	Hatch	Stevens
Cornyn	Hutchison	Sununu
Craig	Inhofe	Talent
Crapo	Kyl	Thomas

NAYS—65

Akaka	Dodd	Lugar
Alexander	Domenici	McCain
Baucus	Dorgan	Mikulski
Bayh	Durbin	Miller
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Bond	Feinstein	Nelson (NE)
Boxer	Fitzgerald	Pryor
Breaux	Graham (FL)	Reed
Brownback	Grassley	Reid
Cantwell	Harkin	Roberts
Carper	Hollings	Rockefeller
Chafee	Inouye	Sarbanes
Clinton	Jeffords	Schumer
Cochran	Johnson	Smith
Coleman	Kennedy	Snowe
Collins	Kohl	Specter
Conrad	Landrieu	Stabenow
Corzine	Lautenberg	Voinovich
Daschle	Leahy	Warner
Dayton	Levin	Wyden
DeWine	Lincoln	

NOT VOTING—2

Kerry	Lieberman

The amendment (No. 1011) was rejected.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. GRAHAM of Florida. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT 975, AS MODIFIED

The PRESIDING OFFICER. There are now 2 minutes evenly divided prior to the next vote.

Mr. ROCKEFELLER. Mr. President, this next amendment has to do with dual eligibility. Never in the history of Medicare have we precluded Medicare beneficiaries from being Medicare beneficiaries. In the underlying bill, for the very first time, we do.

The people I refer to are called dual eligibles. Their average income is $6,500 a year. They tend to be over 85, single women, and very sick. They are on Medicaid. Medicaid, however, is optional according to the States. We know the States to be broke. The fastest growing expense they face is Medicaid. So they are cutting the benefits. They are cutting Medicaid. They will continue to do that. The States have no choice but to cut Medicaid. Some will do it because they wish to, all will do it because they have to.

When that possibility is gone, there is no place for these poorest of the poor to go. They are then, under the underlying bill, precluded from being Medicare beneficiaries. That is wrong. In my budget-neutral amendment I attempt to fix it. I hope my colleagues will support the amendment.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Two things for my colleagues to consider during the consideration of how to vote on this amendment: No. 1 is the money that is available to pay for his amendment, an offset, is the very same amount of money we, Senator BAUCUS and I, are using to offset the cost of a lot of demonstration projects that colleagues have asked us to do, a lot of minor amendments they have asked us to do. If that money is not there, there cannot be consideration given. That is not a threat; it is just a practical aspect of how the budget law works.

Secondly, remember, these dual eligibles are being taken care of very well

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

in our underlying legislation. The point being, they will not be taken care of better. It is just it is going to cost the Federal Government more.

I hope you will take those things into consideration and vote down this amendment.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to amendment No. 975, as modified. The clerk will call the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 47, nays 51, as follows:

[Rollcall Vote No. 257 Leg.]

YEAS—47

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Pryor
Byrd	Graham (FL)	Reed
Cantwell	Harkin	Reid
Carper	Hollings	Rockefeller
Clinton	Inouye	Sarbanes
Collins	Johnson	Schumer
Conrad	Kennedy	Snowe
Corzine	Kohl	Specter
Daschle	Landrieu	Stabenow
Dayton	Lautenberg	Voinovich
DeWine	Leahy	Wyden
Dodd	Levin	

NAYS—51

Alexander	Crapo	Lugar
Allard	Dole	McCain
Allen	Domenici	McConnell
Baucus	Ensign	Miller
Bennett	Enzi	Murkowski
Bond	Fitzgerald	Nelson (NE)
Breaux	Frist	Nickles
Brownback	Graham (SC)	Roberts
Bunning	Grassley	Santorum
Burns	Gregg	Sessions
Campbell	Hagel	Shelby
Chafee	Hatch	Smith
Chambliss	Hutchison	Stevens
Cochran	Inhofe	Sununu
Coleman	Jeffords	Talent
Cornyn	Kyl	Thomas
Craig	Lott	Warner

NOT VOTING—2

Kerry	Lieberman

The amendment (No. 975), as modified, was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. CRAIG. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1066

The PRESIDING OFFICER. There are now 2 minutes equally divided on the Bingaman amendment.

Mr. BINGAMAN. Mr. President, the bill before us has, in my view, a significant flaw in it. We are holding out this prescription drug benefit. But the bill we are considering here says if you want to take advantage of the benefit, you are thereby prohibited from buying any supplemental insurance to cover prescription drugs. Today, people are able to buy Medigap policies that cover prescription drugs. In the future they will not be able to, if this bill becomes law as it is.

My amendment would merely give people the option of buying a prescription drug supplemental policy if they chose to do so. It directs that two policies be developed that would accomplish that.

It is supported by the insurance industry. It is supported by the Consumers Union. Seniors would like to have this opportunity to reduce their risk of substantial out-of-pocket costs.

We ought to provide this benefit.

Mr. GRASSLEY. Mr. President, first of all, let me make very clear that we know that Medigap is very important as part of Medicare. We leave that untouched as it relates to 1965 model Medicare. In fact, many of my Iowa constituents want to keep that. But we as a policy matter have made it a very conscious choice to prevent the sale of wraparound Medigap plans for the new Part D drug benefit. This policy makes sense considering drug plans could be different everywhere else in the United States.

It is impossible to standardize Medigap policies like we did about 15 years ago so that seniors don't get ripped off. But the Congressional Budget Office tells us this new Medigap plan that is before us now will increase the cost of our bill. The cost of this amendment is $1.5 billion over 10 years, according to the Congressional Budget Office. That is because of the increased utilization that comes from having additional insurance.

I share the Senator's concern with gaps in coverage. I wish we didn't have any.

But we believe participating drug plans—especially drug plans delivered by PPOs—will offer benefits in a comprehensive fashion, lessening the need for expensive supplemental policies.

I urge my colleagues to reject this amendment.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the amendment. The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER (Mr. CHAMBLISS). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 43, nays 55, as follows:

[Rollcall Vote No. 258 Leg.]

YEAS—43

Akaka	Dorgan	Levin
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Nelson (NE)
Byrd	Graham (FL)	Pryor
Cantwell	Harkin	Reed
Carper	Hollings	Reid
Clinton	Inouye	Rockefeller
Collins	Johnson	Sarbanes
Conrad	Kennedy	Schumer
Corzine	Kohl	Stabenow
Daschle	Landrieu	Wyden
Dayton	Lautenberg	
Dodd	Leahy	

NAYS—55

Alexander	Dole	McConnell
Allard	Domenici	Miller
Allen	Ensign	Murkowski
Baucus	Enzi	Nickles
Bennett	Fitzgerald	Roberts
Bond	Frist	Santorum
Breaux	Graham (SC)	Sessions
Brownback	Grassley	Shelby
Bunning	Gregg	Smith
Burns	Hagel	Snowe
Campbell	Hatch	Specter
Chafee	Hutchison	Stevens
Chambliss	Inhofe	Sununu
Cochran	Jeffords	Talent
Coleman	Kyl	Thomas
Cornyn	Lincoln	Voinovich
Craig	Lott	Warner
Crapo	Lugar	
DeWine	McCain	

NOT VOTING—2

Kerry	Lieberman

The amendment (No. 1066) was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, very briefly, it is almost 6:25, and we have just completed our 12th rollcall vote. We still have a fair amount of work to do. But in discussion with the managers of the bill and the Democratic leader, it is our intent to finish this bill tonight. I optimistically think we can finish in 2 or 3 hours, or this bill can go until midnight, or 1, or 2, or 3 in the morning.

Part of the problem we are having now is that people are still coming up and submitting amendments, and because we have been working in good faith over the last 2 weeks in the amendment process, we have not set strict filing deadlines.

Now that we are in the last several hours of consideration, I want to make the case and, in fact, plead with my colleagues that any amendments that need to be considered—let us hear about them. Let the managers hear about them in the next 15 minutes. That is the only way we can get a list to deal with them, and we will have rollcall votes on those that are necessary.

There will be a certain number of those amendments looked at by the managers. The ones I encourage you to bring to them for consideration to be accepted need to be budget neutral and have bipartisan support, and they need to be scored by the CBO. People keep bringing amendments forward now. I

will ask—and then I want the Democratic leader to comment—that people, in the next 15 minutes or so, make sure the managers have the amendments. That way we can move ahead. We will finish tonight.

The PRESIDING OFFICER. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I hope we can do as the majority leader has suggested. We have had a good debate. I think this has been an excellent debate. The managers deserve credit for the way they have managed the legislation. We have had 12 rollcall votes today already. It is likely that we will have 16 or 17 by the end of the day, if not more; we had 9 yesterday. More than 50 amendments have now been considered.

I think it is time that we bring the debate to a close. There will be many more opportunities to talk about prescription drugs and health care with the array of legislative challenges that we face relating to health. I think we have been able to do a good deal, and I hope we can get cooperation now on both sides of the aisle. I hope the majority leader will hold to the commitment that we finish tonight. That would accommodate people's travel schedules tomorrow.

If we are going to do that—it is now 6:30—over the course of the next 4 or 5 hours, we have a lot of work to do even with what we know we have to vote on. I hope everybody will cooperate so we can minimize the time required to consider amendments. I hope those who may have remarks to make will perhaps hold off until after final passage and make those remarks after final passage. That would accommodate our time as well.

We will work with the majority leader to see if we can accomplish the schedule he has laid out. I hope we can do so well before the bewitching hour.

I yield the floor.

Mr. FRIST. Mr. President, when we finish this bill tonight, my expectation would be that we would not have votes tomorrow. That is assuming we are going to finish. I encourage anyone who has an amendment that needs to be considered to get it to the managers within the next 15 minutes. If we can do that, we can finish tonight and we will be able to consider each of those amendments, as the Democratic leader said.

I know some people want to talk for an hour but I ask Senators to keep their comments to a few minutes and we can vote throughout the night. We will have the opportunity after final passage tonight, or through tomorrow, to make statements—for those who wish to continue the debate.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. GREGG. Mr. President, I rise to address this bill. I had hoped to do it earlier in the day but, unfortunately, the managers of the bill were unable to work the time in. I certainly regret taking time out of the schedule, which is obviously crowded. I do think it is important to speak up on the issue of this piece of legislation.

This is the most significant piece of spending legislation, and maybe even public policy legislation, outside of an international issue, that I expect I will vote on in my tenure in the Senate. Ironically, when I ran for this job, after serving as Governor of New Hampshire, one of the reasons I sought the job and one of the reasons I wanted to pursue a term in the Senate was that I was concerned about entitlement spending. In fact, during my first few years, I aggressively pursued setting up an entitlement commission to address entitlement spending, which I sponsored with Senator Kempthorne, who came in with me that year, and Senator Coverdell and Senator BENNETT, all of whom came in the year I was elected, in a bill to end unfunded mandates, many of which were entitlement oriented.

I tried to lead an effort in passing legislation to address reform of the Social Security system. I consider that to be a huge entitlement that we confront. My basic reason for seeking entitlement reform and responsibility was that I was concerned that it not only is what is driving the deficits of our country—which they continue to do—but, more importantly, as the demographics shifted in the Nation and we saw the baby boom generation, which represents a huge population, moving toward retirement, we, as a nation, were going to be placing on our children and our children's children an inordinate burden in the area of taxes in order to support the older generation—my generation—which would be retiring. It is because all the major programs, whether they are Social Security or Medicare, are built on the theory that there is a pyramid out there, that there will always be more people working and a lot more people working than those people who are taking their retirement benefits out of the system. That, of course, is the way it began.

Back in 1950, there were 12.5 people working for every person who retired under Social Security. Today, we are down to 3.5 people working for every 1 person retired on Social Security and under Medicare, and that is stressing the system.

Unfortunately, when we hit the retirement situation for the baby boom generation, the largest generation in the history of our Nation, the generation born between 1946 and 1955, we go down to two people working for every one person retired. We go from a pyramid to basically a rectangle, and the result is that we will end up putting an inordinate amount of stress on those people who are working to support those folks who are retired. So we need to address thoughtfully any entitlement expansion, to say nothing of the entitlements that are already on the books.

That is what brings me to the Chamber today to address this legislation because I believe very strongly that needy senior citizens should have a drug benefit. Clearly, prescription drugs have become the new way to treat disease and maintain public health in our Nation. We have been able to move from a system where you had to have invasive activity in the health care system, where you had to go through surgery, to a system where people can, as result of the keen use of our scientific community, take a pharmaceutical and actually have a better life than if they were to go under the knife, have surgery.

This is a revolution, and it is a revolution that is exploding and growing. Biotech activity, the nanotech activity, is only going to lead to more and more and better and better pharmaceuticals coming on the market to help people with their health.

It is absolutely unfair, in my opinion, that people who are in a low-income situation, especially retired people who are on a fixed low income, have to choose between their food and their housing and maybe their pharmaceuticals. That is not right in our society, and we can certainly afford to have that addressed.

It was my hope as we brought forward a pharmaceutical drug benefit for senior citizens that we would do it in a way that would address low-income seniors. Equally important, it is important that a middle-income senior should not have to spend all their assets for health care as a result of pharmaceutical costs. After a certain amount of spending, there should be catastrophic coverage that kicks in, relieving that person of the full responsibility or a large portion of their responsibility for the pharmaceutical cost. That is the type of structure at which we should be looking.

Putting in place this brand new drug benefit, we also have to look at the underlying Medicare system which we all know is fundamentally broken as we look out into the future. When the baby boom generation hits, it simply is not going to work. It is not going to support that generation. That is because it is a 1959 design, an automobile built in the fifties driving on the highways of the year 2000 which, when it gets to 2015, is going to be too old to function effectively. It needs to have put in place forces which are going to cause it to be more efficient, to be more effective in addressing a person's approach to their health care. Those forces have to be basically marketplace oriented. They cannot be price-control oriented.

My hope, my goal, my belief was that we would create a drug benefit that would help low-income seniors and, at the same time, give catastrophic coverage, and that would, fundamentally, reform the Medicare system so that we would end up with a more market-oriented system, something that was going to contain costs as we moved into the outyears.

What did we get? What is before us today? Essentially, what we have before us today is a drug benefit that will plant a fiscal disease that will afflict our children and our children's children. It is a drug benefit that is going to put in place a fiscal disease that will afflict our children for the next 75 years. By afflict them, I mean that our children and our children's children, under the benefit in this bill, are going to have to pay $6 trillion. That is the estimate. That may be the high end. It is somewhere between $4.6 trillion and $6 trillion. When you get into those numbers, it is pretty hard to get very definitive.

That is the burden this drug benefit in this bill puts on our children and our children's children to support my generation which is going to retire and take advantage of it.

That is a huge problem because what we are essentially saying to the person who is working in a restaurant or working in a garage or working on a computer line or working as a sales person, who is young and trying to raise a family, is that they are going to have to pay an inordinate amount of tax burden to support people who are retired with this drug benefit.

That would not be so bad if the drug benefit was not an income transfer from that person working in that garage, working in that restaurant, or working on that computer line to somebody who is a great deal wealthier than they are potentially. That would not be so bad if it was a transfer from that person to people who are low income or whose assets are about to be wiped out because of a drug expenditure.

That is not the way this bill works. The way this bill works is essentially to nationalize the entire drug delivery service for senior citizens to take all the present programs which presently benefit senior citizens for drug benefits—and there are a lot of them; there are a lot of seniors in this country today who already have a drug benefit; something like 76 percent is the estimate—to take a large percentage of those people and move them from their private programs to the public programs.

If you retired from a major corporation or even a smaller corporation in this country, it is very likely that in your retirement package, depending on how aggressive your union was or how successful your company was, you received a drug benefit during your retirement. But when this bill passes, the incentive is going to be to take that drug benefit which presently exists in the private sector under some sort of contractual agreement which you had when you retired and move it out of the private sector and throw it on the taxpayers of America.

Who are those taxpayers going to be? They are going to be our children and our children's children, people who are working for a living, trying to buy their kids a better education, a better home, better food, or even just a nice car or a night out at the movies. Their ability to do that is going to be undermined if this bill goes forward in its present form because so much will have to flow back to benefit people who already have the benefit in the private sector and are now going to be migrated over to the public sector.

Mr. President, $4.5 trillion to $6 trillion is a huge amount of money, a huge burden to put on our children. It is hard to put it in terms that are realistic and are visible when we are talking those type of dollars, but every American child born tonight—and there are a lot of kids being born tonight in America—starts out with a $44,000 debt they have to pay for Medicare for my retirement, for the retirement of everybody in this room, for the retirement of most of the people who are watching who are over the age of 45. They start out with a $44,000 debt.

When this bill passes, they will have another $12,000 to $15,000 added to that debt. So before they get through the first night of their life, as a result of this legislation they are going to owe $60,000. It is not fair. It is not right. We are not doing it the correct way.

There are ways to do this where the system is not nationalized, where all the people who already have a drug benefit are told there is no incentive for them to keep it.

We do not say in the private sector to the people who bought Medigap, to the people who have reached contractual agreements in retirement, to the people who have retained retirement coverage through the private sector, that there is no advantage to them keeping their program or, alternatively, the people who are giving them that program saying they are not going to give it to them anymore, and move those folks onto the public dole, onto the public system. It makes no sense.

Then there is the issue of the underlying question of Medicare. Not only is the drug benefit in this bill fundamentally flawed because it migrates huge numbers of people off the private sector and into the public sector, but the underlying purpose of the Medicare effort in this bill is flawed. If we are going to put in place this huge new benefit for seniors, and especially if it is going to be as grand and as pervasive, where we are basically saying to all seniors that they get a benefit here, no matter what their income is—if that is going to be put in place, that ought to at least be coupled with some sort of reform of the underlying Medicare system to try to bring under control those costs which are driving the outyear liability, which will be the tax burden for our children and their children.

The estimated outyear cost of Medicare that is unfunded is $13.3 trillion. When the baby-boom generation starts to hit the system in 2008, that is when it really starts to crank up, by the year 2020, 2025, when there will be large retirement populations as a result of this demographic shift, $13.3 trillion of unfunded liability.

Unfunded means it is just there. We have to pay it, but nobody has an idea of how they are going to do it. There is no trust fund for it. There is no money out there to do it. So the only way it is going to be done is to raise taxes or to cut the benefit, which is politically probably impossible, so to raise taxes on the young people who are working.

There is a third way, however, to do it, and that is to make Medicare a more cost-sensitive, more thoughtful, more efficient system for delivery of health care. Regrettably, under this bill that does not happen. There is a representation that that might happen, something called a PPO, which is supposedly going to create an opportunity for the private sector to come in and compete with the traditional Medicare system. The price control system will have a chance to compete with a marketplace system. That is the thematic statement of the bill. Unfortunately, it is illusory. It will not happen under the bill. CBO says maybe 2 percent of the people will migrate, will move over, to a PPO system. The administration says it is 48 percent. Logic tells us it is not going to fly, because the bill has been structured to defeat the probability a PPO, a marketplace system, will be allowed to work. All the little gimmicks in this bill are aimed at essentially undermining that.

Classic was the amendment that we passed earlier, which had been so gerrymandered, which was an effort by Senator KYL. So what are we told? Well, even though the bill has these fundamental flaws of having a drug benefit that migrates a large number of people out of the private sector into the public sector and essentially causes low-income working Americans who are young to have to support middle-income Americans who are retired and who had a private sector benefit, and even though the bill has this illusory marketplace representation, basically no real reform of Medicare, we are told we should vote for it because it is going to be improved in conference. At least that is what we are being told on our side of the aisle. I do not know what is being said on the other side of the aisle. Maybe they are not getting that same message. We are being told that by the administration.

The problem is, we are betting on the come. I mean, this is $6 trillion of unfunded liability we are talking about passing on to our kids. It is massive. If this bill were to pass in its present form, or anything near to its present form, it would fundamentally extinguish the torch which the Republican Party has allegedly—and I thought pretty effectively—carried for years which was the torch of spending responsibility.

That is why I came here, as I said when I began my statement. I came to try to do something about controlling the rate of growth of spending in the Federal Government, especially in the area of entitlements. I was told by one of the finest legislators I have ever met

in my experience in 20 years in Government—a man named Barber Conable—one time on the floor of the House when I was mumbling about the fact that some bill was coming through that was a little expensive, you have to understand, JUDD, all Government moves to the left, and it is just a question of how many engines are on that train—think of it as a train—as it moves to the left, and our job as fiscal conservatives is to limit the number of engines that go on that train.

This bill, if it passes in its present form, is going to be all engine, and it is going to undermine our capacity to assure our children they have the opportunity to have the type of lifestyle which we have, because it is going to put a huge and unfair tax burden on them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BREAUX. Mr. President, this morning one of the very able legislative assistants who has worked on this legislation for almost 7 years, going back to the time on the Medicare Commission when we first started doing Medicare reform, was on the floor working with me on amendments in this legislation. She had to temporarily leave because at 5:47 this afternoon she had a little baby girl. That is a very good excuse to not be on the Senate floor. But my legislative director, Sarah Walter, is doing fine. It is a baby girl. The name is yet to be determined, but I wanted to bring that to the attention of my colleagues and all of her colleagues on the professional staff.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho.

AMENDMENT NO. 1087 WITHDRAWN

Mr. CRAIG. Mr. President, this afternoon I will speak to amendment 1087. That amendment was pulled up last night by the manager of the bill, Senator GRASSLEY. I believe that amendment is at the desk.

The PRESIDING OFFICER. The Senator is correct. The amendment has been called up and is pending.

Mr. CRAIG. Mr. President, it is my intent within a few moments to withdraw this amendment, but I thought I should speak to it tonight because I am disappointed at this time that we could not get the scoring from CBO we felt would produce a revenue-neutral bill, or a cost-neutral bill, going into the final hours of this debate.

This is an amendment that produces in this legislation, and hopefully to take up in conference, a consumer-driven health care plan under the new MedicareAdvantage program all of us are talking about at this moment. The Senator from New Hampshire gave a very impassioned speech from the depths of his heart, frustrated that this bill does not balance out and provide enough of the incentives in the market that will offset and create the kind of competitive forces being designed for Medicare with the extension of prescription drugs in it offers.

For a few moments tonight, I did want to speak about that and explain it. As we get into conference with the House, the House has a consumer-driven health care concept within their legislation that is critical. It is something we ought to address.

First, the amendment before the Senate is designed to dovetail with and not disturb the overall MedicareAdvantage competitive dynamic. As a complement to MedicareAdvantage, consumer-driven health care plans would be subject to the same competitive rules as preferred provider organizations.

Second, I emphasize this amendment is carefully crafted. We thought it would ensure budget neutrality. But CBO says tonight, no, and I am not going to be too critical of them; we pushed them very hard in the last good number of days to quickly analyze and bring forth estimates. I think they are simply swamped. We will continue to work with them. We believe what we are offering is budget neutral.

Additionally, the Finance Committee chairman, the majority leader, and the White House have expressed the kind of support for these concepts in amendments. I appreciate it. As everyone begins to examine this structure, they become increasingly enthusiastic that this could become a component of the MedicareAdvantage Program.

For the benefit of my colleagues, let me describe for a moment the key features of this amendment. The amendment establishes a new category of competition within Medicare Advantage designed to encourage participation by consumer-driven health plans. These plans would be subject to the same requirements of PPOs in MedicareAdvantage, including prescription drug benefits and risk adjustment parameters.

Consumer-driven health care is one of the fastest growing innovations emerging in the employer health insurance market. Already 1.5 million Americans are estimated to be in consumer-driven health care in the summer of 2002, and that number is now growing very rapidly.

What is the consumer-driven health care? It harnesses market forces in ways similar to medical savings accounts. However, there are some differences between medical savings accounts and consumer-driven health care plans. For example, enrollees in consumer-driven health care do not have to make contributions to the account. In the private sector, the employer or in my amendment if it were to pass, Medicare makes the contribution to the personal care account. There would be no tax consequence for the senior under this amendment. In other words, it would not be viewed as income. Some in Congress might be familiar with the account because the American Postal Workers Union of the AFL–CIO consumer-driven health care plan is now available. It is in that bundle of choices that Federal employees have today to choose from. More and more employees are signing up for this concept.

This is what the union Web site states: We believe that people who have more control over how their health care dollars are spent are more satisfied consumers and the APWU health plan consumer-driven option is designed to give that kind of control.

It is the very thing the Senator from New Hampshire was talking about. It is what we ought to be striving for to balance off the differences and to create the competitive forces within the MedicareAdvantage program.

Benefits make sense in consumer-driven health care plans. I draw your attention to my chart. My amendment is designed to encourage market flexibility. The information on this chart is one example of what consumer-driven health care plans can provide. Web site education and decision support is one example. In other words, you can go to the Web site, look at it, make choices and decisions based on the best available information. 100-percent preventive care coverage—the very kind of thing we want in modern medicine today. Preventive benefits keep healthy people healthy instead of making the repairs after the human body breaks down.

There are no more barriers to necessary care, including annual physicals, mammograms, and preventive services. All are within this kind of health care plan. All are available today offered by the postal workers.

Patient control of personal care accounts for routine health care services are also included. Unused funds in these accounts then roll over into the next year.

High deductibles, that is true insurance, to protect against financial ruin in an acute health care crisis, in other words, catastrophic coverage.

A limit on annual out-of-pocket spending is an especially important feature. Traditional Medicare does not have an out-of-pocket limit and drives many seniors into bankruptcy. In other words, it limits financial risk when it kicks in at a certain point.

It includes care coordination, disease management, and provider network discounts. Consumer-driven health care gives control of health care back to patients. That is why more and more are enrolling in it. We know today, many who work in the health care area with our seniors know they look at the details of their spending; they look at the billing; they know more about their health care and what is being charged than most people realize. Patients and their physicians, ultimately, with this kind of insurance, join in partnerships to seek the finest care at the most reasonable costs.

Consumer-driven care is especially suited for patients who like to be personally involved in their health care decisions. More and more Americans who can use the necessary information

want that kind of personal involvement.

Consumer-driven care eliminates wasteful Medicare spending, it increases patient awareness of health care costs, and encourages prudent purchasing of health care services. Any unspent funds in the personal care account would be returned to the Medicare trust fund upon the death or the disenrollment. That is a key factor. Federal dollars go into the trust fund and, if there are dollars remaining, they flow back into the trust fund of Medicare upon disenrollment or the death of the individual.

This amendment would be an important addition to the bill. I wish we could get it into the bill tonight. But it would be unfair to the manager of the bill at this time because it cannot get scored. I would not want to drive the cost up of the already-fixed segment of the MedicareAdvantage side. Already, it is less competitive than we would like it to be. I don't want to add to that disadvantage.

We believe ultimately that this will be a budget-neutral program. At that time, it will be the right thing to offer as part of the dynamics that we want to see in a modern health care delivery system and in an improved Medicare with a prescription drug program.

I thank my colleagues for listening. We will return with this when it is a final product. It may well make it into the conference between the House and the Senate. We will be working with our colleagues in the House because they have already provided that kind of a provision within the legislation which they are currently debating and voting upon.

With that, I ask unanimous consent to withdraw amendment No. 1086.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 1086) was withdrawn.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Since Medicare was established in 1965, people are living longer and living better. Today Medicare covers more than 40 million Americans, including 35 million over the age of 65 and nearly 6 million younger adults with permanent disabilities.

Congress now has the opportunity to modernize this important Federal entity to create a 21st century Medicare Program that offers comprehensive coverage for pharmaceutical drugs and improves the Medicare delivery system.

The proposal before the Senate would make available a voluntary Medicare prescription drug plan for all seniors. If enacted, Medicare beneficiaries have access to a discount card for prescription drug purchases starting in 2004. Projected savings from cards for consumers would range between 10 to 25 percent. A $600 subsidy would be applied to the card, offering additional assistance for low-income beneficiaries defined as 160 percent or below the Federal poverty level. Effective January 1, 2006, a new optional Medicare prescription drug benefit would be established under Medicare Part D.

This bill has the potential to make a dramatic difference for millions of Americans living with lower incomes and chronic health care needs. Low-income Medicare beneficiaries, who make up 44 percent of all Medicare beneficiaries, would be provided with prescription drug coverage with minimal out-of-pocket costs. For these seniors, copayments would not exceed 20 percent of the cost of the drugs.

For medical services, Medicare beneficiaries will have the freedom to remain in traditional fee-for-service Medicare for drug coverage, or to enroll in Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), also called MedicareAdvantage, which offers beneficiaries a wide choice of health care providers, while also coordinating health care effectively, especially for those with multiple chronic conditions. MedicareAdvantage health plans would be required to offer at least the standard drug benefit, available through traditional fee-for-service Medicare.

The legislation which is pending has been worked on, now, for many years. I congratulate the chairman of the committee, Senator GRASSLEY, and the ranking member, Senator BAUCUS, for the outstanding work which they have done. This is an extraordinarily complex subject, and it is a very complex bill.

We already know that there are many criticisms directed to this bill at various levels. Many would like to see the prescription drug program cover all of the costs without deductibles and without copays. There has been allocated in our budget plan $400 billion for prescription drug coverage. That is, obviously, a very substantial sum of money. There are a variety of formulas which could be worked out to utilize this funding. The current plan, depending upon levels of income, provides a deductible, then a copay, then what is called a donut hole where the recipient pays the entire costs of their drug coverage, and when it gets to a certain high level, it is catastrophic and there is coverage that pays almost all of it.

As I have reviewed these projections and these analyses, it is hard to say where the line ought to be drawn. It is a value judgment as to what deductibles ought to be, and for whom, and what the copays ought to be and for whom. I am seriously troubled by the so-called donut hole. But it is calculated to encourage people to take the medical care they really need, and at lower levels of income to have certain copays, which it is projected will be affordable. Then, when the costs move into the so-called catastrophic range, to have the plan pay for nearly all of the medical costs.

I think passage by the Senate would be a significant step forward. The House of Representatives, as usual, has a different plan—as is customary, with our bicameral legislative approach. Then the bill can be improved in conference.

The legislative process has the committee turning out a bill, and then many amendments, which generally are not known to Members in advance of brief debate and then votes. It is in the conference, after the bill is analyzed, that another fresh look is taken at the bill to produce the best legislative product in the public interest.

AMENDMENT NO. 983

I have already offered an amendment relating to end of life directives, number 983, which was adopted by unanimous consent.

Commenting on it very briefly, we find statistically that nearly 30 percent of Medicare expenditures occur during a person's last year of life. We find, beyond the last year of life, a tremendous percentage of medical costs occur in the last month, in the last few weeks, in the last week, or in the last few days.

Nobody should decide for anybody else what that person should have by way of end-of-life medical care. What care ought to be available is a very personal decision.

The living wills would give an individual an opportunity to make that judgment, to make a decision as to how much care he or she wanted near the end of his or her life and that is, to repeat, a matter highly personalized for the individual.

But if that decision was made to eliminate some of the very high costs at the very end of life, there would obviously be substantial savings to our medical system. As long as that comports with the will of the individual, that is something which ought to be considered.

The amendment directs the Secretary of Health and Human Services to include in its annual ''Medicare And You'' handbook, to be provided to each beneficiary, a section that specifies information on advanced directives and details on living wills, durable powers of attorney for health care, and directs the Secretary of HHS, in the introductory letter to the ''Medicare And You'' handbook, to reference the inclusion of advanced directives.

AMENDMENT NO. 1085

I have also submitted an amendment which is pending at the desk, amendment No. 1085, which has not yet been acted upon but which I will call up at an appropriate time.

This is an amendment which would update the Medicare physician fee formula. It is a sense-of-the-Senate resolution. The projections from the Medicare payment formula called for a 4.4-percent reduction on March 1, which would have been very problematic. The fact is, the Center for Medicare and Medicaid Services, CMS, now projects a Medicare conversion factor figure of 4.2 percent will be projected for the year 2004. This reduction threatens to destabilize an important element of the

Medicare Program; namely, physician participation and willingness to accept Medicare payments. This instability is a result of the sustainable growth rate, a system of annual spending which targets physicians' services under Medicare.

This sense-of-the-Senate amendment would provide that the conferees on Medicare reform and prescription drug legislation should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years, and should consider adding provisions which would mitigate the swings in payment, such as establishing multiyear adjustments to recoup the variance and creating tolerance corridors for variations around the updated target trend.

AMENDMENT NO. 1118

I have also submitted an amendment designated as amendment No. 1118, which provides for a lifestyle modification program demonstration. This is projected on the factor that heart disease kills some 500,000 Americans each year. The costs of coronary disease currently relate to an expenditure of some $58 billion annually. There has been a test program of the Medicare lifestyle modification program operating in some 12 States which has been demonstrated to reduce the need for coronary procedures by 88 percent. This program could reduce cardiovascular expenditures by as much as $36 billion annually.

Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater. This program has also been applied to men with prostate cancer, who have shown significant improvements in prostate cancer markers using a similar approach in lifestyle modifications. My amendment expresses the sense of the Senate that the Secretary of Health and Human Services should carry out the lifestyle modification program demonstration at the national level and then provide it on a permanent basis, and include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis.

I have submitted one additional amendment, which is No. 1128 and which relates to State pharmaceutical assistance programs for the elderly and disabled. Currently, 18 States have comprehensive pharmacy assistance programs which provide prescription drug coverage for more than 1.1 million older and disabled Americans.

In my own State, Pennsylvania's Pharmaceutical Assistance Contract for the Elderly, known as PACE, established in 1984 provides prescription drug coverage to 230,000 Medicare beneficiaries, the vast majority of whom have incomes below 160 percent of the Federal poverty level. This enrollment is comprised largely of 70- and 80-year-old widows who have multiple diseases and limited educational background who have been enrolled in the PACE program for more than a decade.

There is a serious concern that if there is not a coordinated program, people will not be informed as to how to move from PACE to another program. This affects not only Pennsylvania but, as I stated, 17 other States.

The pending bill does not provide for coordination of benefits between State pharmaceutical programs and private insurers. Without a coordination of benefits for State plans to facilitate enrollment in private plans, many of these State program beneficiaries will be unable to assess the new Medicare drug benefit.

This amendment provides for coordination of benefits between States and private insurance companies and facilitates the enrollment of State pharmacy assistance beneficiaries in the private plans. Without this amendment, the majority of seniors enrolled in their State pharmacy programs will not be able to effectively access private plans.

I note the presence of other Senators who are seeking recognition. I attempted to be brief in my general statement about the bill and also in my descriptions of these four amendments, one of which has already been adopted.

I ask unanimous consent that at the conclusion of my remarks, there be printed in the RECORD a summary of the end-of-life directive amendment, a summary of the updating of the Medicare physician fee formula, a summary of the lifestyle modification program, and a summary of the State pharmaceutical assistance programs for the elderly and disabled, and also printed in the RECORD at this point the amendments themselves.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SUMMARY ON THE END OF LIFE DIRECTIVE AMENDMENT

The purpose of this amendment is to make it easier for individuals to make their own choices regarding their treatment when nearing the end of their life.

A health care advance directive is a document where a beneficiary gives instructions about their health care if, in the future, that beneficiary cannot speak for him or herself. The beneficiary can give someone they name (''agent'' or ''proxy'') the power to make health care decisions on their behalf. They may also give instructions about the kind of health care they do or do not want.

In a traditional Living Will, a beneficiary would state their wishes about life-sustaining medical treatments if he or she is terminally ill. In a Health Care Power of Attorney, one appoints someone else to make medical treatment decisions for the beneficiary if they cannot make them on their own.

Unlike most Living Wills, a Health Care Advance Directive is not limited to cases of terminal illness. If the beneficiary cannot make or communicate decisions because of a temporary or permanent illness or injury, a Health Care Advance Directive helps them keep control over important health care decisions.

Observers have long noted that individuals incur the majority of health care costs in the last few months of life. Nearly 30 percent of Medicare expenditures occur during a person's last year of life.

Your amendment directs the Secretary of HHS to include in its annual ''Medicare and You'' handbook, which is provided to each beneficiary, a section that provides information on advanced directives and details on living wills and durable power of attorney for health care; and directs the Secretary of HHS, in the introductory letter to the ''Medicare and You'' handbook, to reference the inclusion of advanced directives information.

SUMMARY ON THE AMENDMENT TO UPDATE THE MEDICARE PHYSICIAN FEE FORMULA

Earlier this year, Congress passed legislation as part of the Fiscal Year 2003 Omnibus Appropriations bill (H.J. Res. 2) that avoided an impending 4.4 percent cut in the Medicare conversion factor. Although this change resulted in a welcomed 1.6 percent increase in the Medicare conversion factor for 2003, the Centers for Medicare and Medicaid Services' (CMS) preliminary Medicare conversion factor figure predicts a 4.2 percent reduction for 2004.

It is clear that this scheduled 4.2 percent reduction in the physician reimbursement formula threatens to destabilize an important element of the Medicare program, namely physician participation and willingness to accept Medicare patients.

The primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare.

The sustainable growh rate (SGR) system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for the immediate recoupment of the difference.

Both administrative and legislative action are needed to return stability to the Medicare physician payment system.

In its March 2003 report, the Medicare Payment Advisory Commission (MedPAC) stated that if ''Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary in 2004.''

With 17 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania's physicians have already suffered a $128.6 million loss, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $553 million or $17,396 per physician for the period 2003–2005.

Your amendment expresses the sense of the Senate that the conferees on Medicare reform and prescription drug legislation should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating ''tolerance'' corridors for variations around the update target trend.

SUMMARY OF THE AMENDMENT ON THE LIFESTYLE MODIFICATION PROGRAM

Heart disease kills more than 500,000 Americans per year. The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58 billion annually.

The Medicare Lifestyle Modification Program (also known as the Dean Ornish Program for Reversing Heart Disease) has been operating throughout 12 states and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36 billion annually.

Lifestyle choices such as diet and exercise effect heart disease and heart disease outcomes by 50 percent or greater.

Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dieticians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

The National Institutes of Health estimates that 17 million Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

Lifestyle modification programs are superior to medication therapy for treating diabetes. Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification. These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

Your amendment expresses the sense of the Senate that the Secretary of Health and Human Services should carry out the Lifestyle Modification Program Demonstration at the national level on a permanent basis and include as many medicare beneficiaries as would like to participate in the project on a voluntary basis.

SUMMARY OF THE AMENDMENT ON STATE PHARMACEUTICAL ASSISTANCE PROGRAMS FOR THE ELDERLY AND DISABLED

Currently, 18 states have comprehensive pharmacy assistance programs that provide prescription drug coverage to more than 1.1 million older and disabled residents.

The majority of these beneficiaries receive life saving medications to treat high blood pressure, heart disease, arthritis, diabetes, and eye disease.

Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE), established in 1984, provides prescription drug coverage to 230,000 Medicare beneficiaries, the vast majority of whom have incomes below 160% of the federal poverty level. This enrollment is comprised largely of 70 and 80–year-old widows who have multiple disease states, and less than a tenth grade education, and have been enrolled in PACE for more than a decade.

Currently, the pending bill the Senate does not provide for 'coordination of benefits', between state pharmaceutical programs and private insurers. Without a coordination of benefit mandate and a role for the state plans to facilitate enrollment in private plans, many of these state program beneficiaries will not be able to access the new Medicare drug benefit.

This amendment provides for the coordination of benefits between states and private insurance companies, and facilitates the enrollment of state pharmacy assistance beneficiaries into private plans, without this amendment the majority of the seniors enrolled in their state pharmacy programs will not be able to effectively access private plans.

AMENDMENT NO. 983

(Purpose: To provide medicare beneficiaries with information on advance directives)

On page 676, after line 22, insert the following:

SEC. ___. PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b-2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking ''The notice'' and inserting ''(1) The notice''; and

(3) by adding at the end the following:

''(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

''(B) In this section:

''(i) The term 'advance directive' has the meaning given such term in section 1866(f)(3).

''(ii) The term 'medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.''.

AMENDMENT NO.

(Purpose: To permit existing State pharmaceutical assistance programs to wrap around the coverage provided by Medicare Prescription Drug plans and to facilitate the enrollment of eligible beneficiaries for prescription drug coverage)

On page 133, after line 25, insert the following:

''(3) COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

''(B) ELECTION.—Under the process established under section 1860D–3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or MedicareAdvantage plan through the existing State pharmaceutical assistance program.

''(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—In this paragraph, the term 'existing State pharmaceutical assistance program' means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004.''

AMENDMENT NO. 1085

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating ''tolerance'' corridors for variations around the update target trend.

AMENDMENT NO.

(Purpose: To express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries)

At the end of title VI, insert the following:

SEC. ___. SENSE OF THE SENATE REGARDING THE ESTABLISHMENT OF A NATIONWIDE PERMANENT LIFESTYLE MODIFICATION PROGRAM FOR MEDICARE BENEFICIARIES.

(a) FINDINGS.—Congress finds that:

(1) Heart disease kills more than 500,000 Americans per year.

(2) The number and costs of interventions for the treatment of coronary disease are rising and currently cost the health care system $58,000,000,000 annually.

(3) The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiac procedures and could reduce cardiovascular expenditures by $36,000,000,000 annually.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, registered dietitians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

Mr. SPECTER. I thank the Chair. I yield the floor.

Mr. REID. Mr. President, I ask unanimous consent that the distinguished Senator from West Virginia be recognized to speak on the bill for up to 20 minutes and that following his statement, the Senator from Florida, Mr. GRAHAM, be recognized for 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from West Virginia.

Mr. BYRD. Mr. President, I thank the distinguished Democratic whip for his thoughtfulness and courtesies.

Mr. President, just last month we celebrated Older Americans Month, a time of reflect on the contribution of older Americans to our society—to their families, their communities, and their Nation. For many seniors, these ''golden years'' are the most valuable time in their lives, a time when they may no longer have the day-to-day aggravations of work, and can concentrate their time and efforts on something else—grandchildren, lifelong passions, learning new skills, acquiring knowledge, or participating in creative endeavors.

But that is not the case for many seniors. In too many instances, seniors who have worked and saved a lifetime find that today's cost of living far exceeds the level they can afford. Despite planning and frugality, today's costs simply have exceeded the means of many older Americans, and they find that the visions of the secure life they had expected post-retirement are now more a nightmare than a dream.

A big part of the problem is the value that our society places on the elderly—it is much too low!

Age discrimination is all too prevalent in the workplace. Long-held stereotypes—that seniors are slow, forgetful, less competent than their younger counterparts—limit opportunities for older workers and prevent businesses from benefiting from well-honed talents. Those stereotypical images are just plain wrong.

To be 65 today is not like it was to be 65 when I was a young man. The idea of pushing senior citizens out of the door to make room for younger workers is, itself, antiquated.

I grew up during the Great Depression when one had to work hard just to get a job and then work even harder to keep it. People of my generation, the generation Tom Brokaw has referred to as ''The Greatest Generation''—I kind of like that term, ''The Greatest Generation,'' although I don't quite agree with it.

Seniors in the workforce can be a positive and inspiring force.

The reason I don't agree with it is that I think the greatest generation was that generation that produced the Constitution of the United States and produced this constitutional system of government that we have today. We will talk more about that on a later day.

I grew up during the Great Depression when one had to work hard, as I say, just to get a job and then work harder to keep it. People of my generation, coming from that experience, developed a work ethic which can inspire young people today. Seniors in the workforce can be a positive, inspiring force. Moreover, better health care and healthier lifestyles have extended lifespans and led to a senior population with vigor and vitality.

But when the health of seniors does decline, this Nation does an embarrassingly poor job of dealing with their needs. Child care has become a booming business in this Nation. Millions are spent on bigger, brighter, better child care centers—lively places, filled with happy activities and stimulation. That is as it should be. But when the elderly need daily care, too often they are relegated to dim, overcrowded centers, places that serve as little more than warehouses that provide busy work for the hands, and little to fill the heart and soul.

Inestimable numbers of scam artists focus on the elderly. The offices of Attorney Generals across the nation are besieged with complaints from seniors who were prey for some con artists and ended up losing their life savings. Newspapers carry stories about CEOs of big, once-profitable companies who are awarded big bonuses, while the pensions of loyal retirees are squeezed. When this is how we treat our seniors, something is wrong with America.

Older citizens should rejoice in their long lives, in their collected experiences, and in their accomplishments. But in America today, magazines showcase images of young, vibrant models. Movies and television shows feature youthful actors and actresses. No one wants to be ''old'' anymore. It has become a tarnished word.

Older citizens today are generally not appreciated as either experienced ''elders'' or possessors of special wisdom. Older people are respected only to the extent that they remain capable of working, exercising, and taking care of themselves. In American culture, increasing age seems to portend decreasing value as a human being. It should be just the opposite.

How did the American culture develop such blatant disregard and disrespect for the elderly? Well, however we got to such a point, we are definitely here.

Senior citizens need to rise up and make their voices heard or else they will be forgotten, especially when it comes to policy formation that directly affects them, such as Medicare legislation before us today. The Senate is in the midst of an important debate on a major restructuring of Medicare—a debate that will shape the health care choices of millions of our Nation's senior citizen for years to come.

The Medicare program is in desperate need of renovation to meet the needs of today'a older citizens living in a new era with dramatic advancements in the delivery of health care. Medicare was designed to provide health care benefits to the most vulnerable segments of the population, the elderly and the disabled.

When I voted, way back in 1965, to establish the Medicare program, pharmaceutical treatments, then more of footnote in health care, were not nearly as commonly available as they are now.

Today, they are a primary form of medical care and often substitute for more costly treatments like hospitalization and surgery.

Today, 40 million Americans rely on Medicare to help provide for their medical needs. With more than one-third of all Medicare beneficiaries lacking insurance coverage for the cost of needed medications, finding affordable prescription drug coverage is a critical issue for our Nation's seniors. Prescription drugs are an essential tool for treating and preventing many acute and chronic conditions, but Medicare fails to cover them on an outpatient basis. Too many seniors and disabled persons in this country, especially those living on fixed incomes, are forced to choose each month between paying for food and paying for shelter, or buying the essential medicines that their doctors have prescribed.

Our Nation's senior citizens are losing their patience. They are losing their dignity. And they are fed up with fast-rising drug costs that they cannot afford. Older citizens should not have to travel in bus loads to Canada and Mexico just to obtain the medications their doctors prescribe. What does it say about this country and its values when we fail to take care of our elderly citizens whose lifetime of work and sacrifice and dedication and industry helped to endow this country with the greatness it now enjoys?

Mr. President, I fear that the legislation before us today is a glaring example of how this Nation shortchanges our senior citizens. We are not taking care of our elderly citizens as they wrestle with the most serious issue in their lives. We are offering a partial fix to assuage senior anger. This bill fails to go far enough to meet the needs of our Nation's senior citizens. I am concerned that this measure would force Medicare beneficiaries to rely on a private, untried, untested, drug-only insurance market for their prescription drug coverage, rather than the traditional Medicare program that they know and trust. We split drug benefit off from Medicare?

I am concerned that this administration and some Members of Congress plan to phase out the traditional Medicare program as an option for new beneficiaries in the future. Some people have asserted that this legislation is merely a Trojan horse designed to get rid of Medicare. I sincerely hope that this is not the case, but there is something very suspicious about this particular horse.

I am worried that we may be endorsing the slow suicide of one of the most popular and effective Government programs in history. I have been down this tortured road before during my 50-year tenure in Congress. My constituents and others around the Nation are reeling from public programs that have been turned over to the so-called free market. Utility rates, cable rates, airline rates, you name it, the free market has ensured exorbitant prices with diminished service, especially for rural areas such as West Virginia. Pensions and retirement security have taken a similar beating.

The Medicare program, for which I voted in 1965, was originally created because the private sector did not offer affordable and reliable health insurance to the elderly and the disabled. Health care has certainly changed in the past 38 years, but what has not changed is the fact that the private market does not want to insure people who are old or disabled or likely to need care. Mr. President, what is the rationale for inventing some new hocus-pocus type of plan that exposes senior citizens to the whims of private insurance companies which may be more interested in profits than in providing comprehensive drug benefits?

Mr. President, this legislation, as currently designed, does not even provide sufficient prescription drug coverage. It would cover less than a quarter of Medicare beneficiaries' estimated drug costs over the next 10 years, and the complicated coverage formula has a large donut hole providing zero coverage just when seniors might need it most.

This legislation also includes copayments, premiums, and deductibles that may be unaffordable for man low- and middle-income seniors. The $35-per-month premium, the 50-percent copay, the $275 annual deductible, and the $5,800 stop-loss amount that we have heard so much about are only suggested amounts and certainly not a guarantee. A closer look at the fine print of this legislation reveals that private insurers could choose to charge senior citizens double or even triple these amounts.

Let's fact it, the kind of prescription drug benefit that we have repeatedly promised our Nation's elderly citizens, and that they now rightly expect, would cost at least $800 billion over the next decade. Yet the administration and congressional Republicans have only allocated $400 billion for the next 10 years for a Medicare prescription drug benefit. And during this same period, drug costs for senior citizens alone, according to the Congressional Budget Office, are expected to total almost $2 trillion.

One of the primary reasons this legislation contains such glaring deficiencies in the drug benefits being offered to seniors is not difficult to understand—this administration and Congress have chosen to make tax cuts a higher priority than prescription drugs for senior citizens. Since the Federal Treasury has already been raided, there is not enough money to adequately cover prescription drugs. Senior citizens ought to be outraged—outraged. Senior citizens ought to be outraged. I am a senior citizen, and I represent a State with a lot of senior citizens, and I am outraged! I am outraged!

What is the rationale for waiting until 2006—conveniently right after the next election cycle—to implement this legislation? Why wait? What are we so afraid of? We had Medicare up and running less than 12 months after creating it from scratch in 1965. So why can't we do it now? Mr. President, it seems that this Congress is trying to pull the wool over the eyes of our Nation's senior citizens—hoping to claim victory and keep senior citizens in the dark until they become painfully aware of the fine print—the fine print—of this legislation upon a visit to their local pharmacist in 2006.

Mr. President, this legislation, as it stands, does not provide the real, guaranteed, defined benefit that our senior citizens desperately need and does little to address the high cost of prescription drugs. I had hoped we could improve this legislation through the amendment process, but that does not appear to be the will of this Senate in the mad dash—the mad dash—to reach final passage before the recess. We should do better for our older citizens. We owe them so much.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM of Florida. Mr. President, this is a sad evening for me. I rise to oppose the prescription drug bill that we will be voting on shortly. No issue that we have debated over recent years has held so much promise, the promise that we could fundamentally reform Medicare from a program which today requires you to be sick enough to go to the doctor or the hospital in order to get services to one that would have its focus on wellness, including the opportunity to participate in a voluntary, comprehensive, universal, and affordable plan of prescription drugs.

Prescription drugs are, in today's health care system, a fundamental part of maintaining good health. I have spent the better part of the last 5 years, as have so many of my colleagues—and in the case of Senator BYRD, many more than 5 years—attempting to deliver a meaningful drug benefit for our Nation's seniors. I have learned some things during this period. Unfortunately, what I have learned convinces me that the bill before us tonight is not worthy of America's seniors. Because what we are about to deliver is a hollow promise and little else.

Why do I believe this? Why have I come to the conclusion that this proposal is not worthy of using all of the years of enthusiasm and commitment of America's seniors and many of those such as myself who represent a substantial number of those seniors? Why do we feel that this path is not acceptable?

First, there are gaps in the benefit which are too large to overcome. I could not go home to Florida or to any other place in America and tell people that this legislation is a good deal. This is especially the case for those with large out-of-pocket expenses. How do we tell a senior who halfway through the first year in which this

will be available, 2006, their drug costs will double but they will continue to pay the monthly premiums?

That would be analogous to car insurance which says: You will be covered in case you have an accident from January to August but if you have one from September to December it is out of your pocket. Who would buy that automobile coverage?

The worst thing is that millions of seniors will never realize they have bought in to such an inadequate policy until it is too late.

Second, this bill does not provide a universal drug benefit. Under this plan, for instance, if you are a Medicare beneficiary but you are also poor, you will not get the prescription drug benefits for Medicare. That is right. Seniors at 74 percent or below the poverty level would be excluded from the Medicare benefit. They would get their prescription drugs through Medicaid. This is a clear effort for the Federal Government to unload a substantial part of its prescription drug expenses on the States, States which are already struggling with serious financial problems.

It is for that reason that the National Governors Association has opposed this design saying:

It is not good health policy. It is not good precedent.

The argument is made that this is all we can do. We cannot do better because we do not have the resources to do better. This is analogous to the child who just has shot his mother and his father and now throws himself on the mercy of the court claiming to be an orphan. We have made the decision to be in the financial status that we are, and the consequence of that decision, as we debated a few weeks ago when we adopted the Senate's budget for the year, is that we are going to have to have an unnecessarily and unacceptably low level of financial support for a meaningful prescription drug benefit.

Third, this plan will cost many seniors more than they can afford. From repeated surveys, seniors have stated that they need a plan with no deductible so that coverage starts from the first prescription. And they need a premium of no more than $25 a month. Yet the sponsors of this bill suggest a $275 deductible and an average premium of $35 per month, an average premium which could actually be higher because the private insurance companies will determine the level of the premium. You can look through the over 600 pages of this bill and not find the number $35. That is a hope number but the actual number will be determined by the private insurance carriers.

Fourth, this bill would subject millions of America's seniors to a giant experiment, a giant experiment in delivering prescription drugs through an untested delivery system, a system which is unheard of in the private markets. It is stated that this system will be justified because it will be efficient and will use the power of competition to suppress cost. If this was such a good system, why don't we provide it for all Federal employees so they can get, we as Federal employees can get, the benefit of this greater efficiency and cost savings? The reason is because insuring drugs only is not an actuarially sustainable risk. It has been analogized to buying a fire insurance policy just to cover the kitchen. No insurance company is going to sell you a policy for the most vulnerable area of your house to actually experience a fire.

That is why no private insurance plan is available today which will provide you a prescription-only coverage. That is the equivalent of the kitchen in terms of its intensity and potential for explosion of cost within health care. Yet we are about to say that some 40 million of the most vulnerable and frail Americans are going to be the experiment for this ideology.

I have said it before and I will say it again: There is simply no reason to subject our Nation's seniors to this grand experiment, particularly when we already know what works. There is no reason to pump extra dollars into private insurance plans.

A few hours ago we adopted an amendment which will pump in $6 billion for additional benefits to HMOs. Those $6 billion could have been used to reduce the monthly premium, to close part of the gap of coverage. But what did we decide to do? We are going to give it to the HMOs so the Federal Government will be assuming more of the risk of coverage as opposed to these plans whose reason for being is to assume the risk and, therefore, have the incentive to provide the most efficient plans.

We are begging these HMOs to participate in the Medicare Program for the sake of a private sector veneer, for the sake of an ideology untested. We actually tried a version of this before. Guess what. It didn't work. I speak from experience. Medicare HMOs have dumped hundreds of thousands of Floridians from their rolls as they have in virtually every other State, and more are being dumped each day. But this Congress, rather than look to the reality of past experience, has determined to embark on this collision course at the expense of seniors and at the expense of common sense.

Fifth, I fear that we will have difficulty in convincing healthier seniors to sign up for this prescription drug benefit. As it is with virtually all insurance plans, it is critical that there be a mixture of those who have the greater likelihood of experiencing the risk with those who have the lesser likelihood in order to create an actuarially sound balance.

One-third of our seniors would not break even under this legislation. That is, one-third of seniors with drug spending of less than $1,135 per year would get no benefit should they voluntarily sign up for this plan. Therefore, how do we induce them to do so? One of the ways that we had induced them in the past was to have a meaningful catastrophic care provision, so that seniors who, today, are relatively healthy are insuring themselves against the risk that they might have a disease or an accident that would put them into much higher prescription drug costs.

Last year we determined that the level necessary to induce a large enough number of healthy seniors to participate was $4,000 in an annual drug expenditure, and if their previous employer made a contribution, that would be counted toward that $4,000. This bill increases the level at which a person would be eligible for catastrophic care to $5,800, and employer contributions would be excluded. This new level is significantly less of an inducement for healthy seniors to participate, and the effect is likely to be disappointing levels of participation.

Mr. President, I ask unanimous consent that a copy of today's front page article ''For Struggling Seniors, Medicare Drug Plan's Proof Is in the Purse'' from the Washington Post be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. GRAHAM of Florida. The reporter interviewed active, healthy seniors at centers in Cleveland, OH, and they were skeptical of the cost of the benefits that would be offered under this bill.

Sixth, the fact that this bill doesn't take effect until 2006 is another brutal hoax on seniors, truly an abusive, shameful, misleading ploy.

The fact is, many of those who most need prescription drug coverage today simply will not live long enough to get any benefits under this plan. As much as I have wanted to vote for a drug bill, for those reasons, I simply cannot vote for the one before us this evening.

We have lost our focus. The focus should be on the Medicare Program in reform and how to help our 40 million seniors and disabled persons. Instead, the focus is everywhere else—insurance companies, drug companies, and hiding the flaws which ought to be exposed.

This focus is often presented as the issue of choice. Choice has different meanings. For the idealog, choice means a choice among delivery systems. But for seniors, choice means doctors, hospitals, and, hopefully, prescription drugs. Yes, this gives seniors a choice among delivery systems. For instance, if you are one of the 89 percent of seniors in a fee-for-service Medicare Program, you will get a choice of between two or more prescription drug plans. If that fails, you will then drop back into traditional Medicare.

The Stabenow amendment, which was defeated earlier in the debate, would have given seniors at least real choice between a prescription drug delivery system and fee-for-service Medicare as the delivery system.

The tragedy is that we know what we ought to be doing. What we ought to be doing is building on the strengths of

our current Medicare system—one of the most popular health care programs in this Nation's history. We also ought to be seeing that we have a plan that is affordable and comprehensive.

I think the dye is cast and this bill is likely to pass the Senate. I will be hopeful that in conference it will improve but I think there is every likelihood to suspect that it will get worse. It will be my intention to introduce legislation that will correct the flaws of this legislation which, among other things, will provide for a patients' bill of rights, so that as we herd more seniors into HMOs, at least they will know the standards by which they will be asked to operate within that.

We are beginning to hear the first rumblings of dissent. Today's Miami Herald looked at the legislation before the two Houses and this is what they had to say:

House and Senate bills attempting to offer prescription drug cost relief to Medicare seniors can be summed up with the movie title, Dumb and Dumber.

Both bills promise dubious benefits without providing the security that seniors want and have, with traditional Medicare health coverage.

I ask unanimous consent that a copy of that editorial be printed in the RECORD after my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 2.)

Mr. GRAHAM of Florida. Medicare has served our seniors superbly. And where it has not, as in the area of prescription drugs, it has been because Congress has not allowed it to do so.

I hope when this bill comes back from conference, it will be better but I doubt that will be the case.

The PRESIDING OFFICER. The Senator has consumed 15 minutes.

Mr. GRAHAM of Florida. Mr. President, I will vote no today in the hopes that soon we will have an opportunity to pass a prescription drug bill that will fully meet the needs and expectations of older Americans.

EXHIBIT 1

[From The Washington Post, June 26, 2003]

FOR STRUGGLING SENIORS, MEDICARE DRUG PLAN'S PROOF IS IN THE PURSE

(By Ceci Connolly)

CLEVELAND—As the Medicare drug package moving through Congress takes on an air of inevitability, Washington politicians are already jostling for credit. But in this working-class city 370 miles from Capitol Hill, prospects for the plan's eventual success may lie deep inside the handbags of women such as Marie A. Urban.

Stashed in there are her monthly Social Security statement, a half-dozen prescription discount cards and insurance letters rejecting several recent medical claims. The scraps of paper—creased and scribbled on—document a life near the financial edge.

After working 24 years as the secretary at St. Paul's Shrine, Urban, 72 collects $843.70 a month in Social Security. After housing and Medicare payments, she has $459 for utilities, food, car insurance, taxes and medication. ''Some months I have 87 cents to live on,'' she said. With her drug bills this year already exceeding $1,500, she said she probably will try to cobble together the money to buy the prescription coverage that lawmakers plan to offer Medicare recipients.

''I don't know,'' she said. ''My finances right now are very tight. I guess I'd have to go with it.''

In interviews at two senior centers here, Urban and other retirees expressed deeply mixed feelings about the voluntary prescription drug benefit scheduled for votes in Congress as early as today. They exhibited a visceral distrust of Washington, voicing skepticism that elected officials would deliver a package that fits their health needs and budgetary constraints—in time for them to use it. They were disappointed that in most cases, benefits would not begin until a person spent nearly $1,000 a year on prescription drugs. And they were annoyed—but not totally surprised—that the program would not begin until 2006.

''They've been kicking this ball around for a while,'' said Carrie Adams, 66. ''If they wanted to solve this, they would. The people with the ball are not relating to the people out here.''

Ruby Bogus, 83, was a bit more sanguine. ''We just have to live longer, girls,'' she said.

Both the House and Senate plans would require seniors to pay about $35 in monthly premiums and an annual deductible of $250 to $275 before receiving any subsidy. The Senate plan would cover half of a person's annual drug expenditures between $276 and $4,500. The recipient would pay the next $1,300 in prescription costs. If the person's total drug costs rose above $5,800 in a year, subsidies would resume.

The House bill would offer retirees an 80 percent subsidy on drug bills between $251 and $2,000 and no coverage for the next $1,500 worth of medications. The ''catastrophic coverage'' would begin when costs reached $3,501.

Asked whether either plan was attractive, Emily Eckert pulled a tiny notebook from her purse. It listed her daily medications: two pills to control sugar, one for high blood pressure, another to regulate potassium. Using her People's Drug Mart discount card—also tucked in her pocketbook—Eckert spends about $100 a month on prescriptions, plus $22 for diabetes test strips.

At 79, she has outlived two husbands, but at a high cost. Caring for her first husband, who had cancer, and the second, who had diabetes, wiped out $7,000 in savings and two life insurance policies valued at $3,000. Eckert has been in bankruptcy and worries about helping her three children, 10 grandchildren and 10 great-grandchildren.

''If it wasn't for this center, I'd be starving,'' she said, referring to the Senior Citizens Resources facility in the Old Brooklyn neighborhood. She wants to buy the drug coverage proposed for Medicare but isn't certain she will be able to pay the premiums.

The situations of Marie Urban and Emily Eckert may sound dire, but in many respects they are typical for the millions of senior citizens and disabled people who rely on Medicare for their health care. Not poor enough to qualify for Medicaid, yet not fortunate enough to have substantial savings or a lucrative retirement package, such people have clamored for years for help with the rising cost of medication.

Assuming the House and Senate pass their spending bills and then resolve their differences, Congress hopes to answer those demands by spending nearly $400 billion on drug coverage over 10 years. The legislation would mark the largest Medicare expansion in the program's 38-year history and could provide a political boost to President Bush and fellow Republicans who campaigned on the promise of alleviating drug costs.

However, as the conversations in Cleveland illustrated, many older Americans are watching with guarded optimism and could revolt if the final package fails to meet expectations. That would dash Republicans' hopes of taking away an issue that has been mostly associated with Democrats for decades.

Their elderly residents' fundamental question is whether they would save money under the new plans. The answer isn't easy.

Urban is torn. Most years she spends about $800 on medicine, so a benefit that does not begin paying off until after $1,000 in out-of-pocket spending looks like a money loser for her. But this year, a mysterious infection and several hospitalizations pushed her drug bills to $1,500, and the federally subsidized insurance would have saved her money. Urban drives 30 minutes to several pharmacies in the Cleveland suburbs to shop for the best deals. She gets agitated thinking about the complex math of the new proposal.

Howard Bram, 77, also complained about the complexity of a program that will involve choosing a plan, tracking out-of-pocket expenses and knowing when the coverage kicks in, lapses and then resumes in severe cases, all according to a sliding scale of benefits.

''It's just gonna blow their minds,'' he said. Bram is trying to figure out whether the drug plan would put a significant dent in the cost of the eight medications he takes.

Carrie Adams and Jean Nagorski are precisely the sort of customer-patients that Medicare will need—comparatively young, healthy and with some retirement income. Yet both women doubt they would buy the Medicare drug coverage because they believe they get a better bargain with the current supplemental insurance plans. Without clients such as Adams and Nagorski, policymakers worry, the new Medicare package will draw the oldest, sickest and poorest patients, leading to skyrocketing costs.

Despite the plan's limits, Adams predicted many friends will sign up for any program that might lower their drug bills. ''They're gonna jump on this like white on rice,'' she said.

Zev Harel, 73, agreed.

''There are always those who hope for a revolution, but what has worked in the United States is evolution,'' said Harel, a professor at Cleveland State University and board member of the Western Reserve Area Agency on Aging. Many of his friends will be disappointed with the limits of the drug coverage, he said, but he considers it ''a major improvement over the current situation.''

If analyzed in the context of other types of insurance, the Medicare drug plan is a reasonable approach, Harel said. ''This follows on the principle of purchasing protection.''

But many others said the fundamental promise of Medicare—a system they supported through payroll taxes throughout their careers—has always been health care for all, and in today's world, that should include prescriptions.

''The politicians seem to say it's better than nothing, and we should be grateful,'' Urban grumbled.

To some retirees here, who chip coupons and follow the news, Washington's Medicare is just the latest example of the doings of out-of-touch elitists.

Nagorski reached into her purse and retrieved a recent newspaper clipping detailing the personal riches of the United States' elected leaders. The article identified several millionaires, including Sens. Bill Frist (R-Tenn.), Edward M. Kennedy (D-Mass.) and Ohio's senators, Mike DeWine and George V. Voinovich, both Republicans.

''Do you really think they care about the average person with what they earn?'' Nagorski asked. ''I don't think any of them are ever going to have to live on $1,100 a month.''

[From the Miami Herald, June 26, 2003]

THE WRONG PRESCRIPTION—CONGRESS CONSIDERS INADEQUATE BILLS

U.S. House and Senate bills attempting to offer prescription-drug cost relief to Medicare seniors can be summed up with a movie title: Dumb and Dumber. Both bills promise dubious benefits without providing the security that seniors want, and have, with traditional Medicare health coverage.

With election-year politicking started already, the bad news is that a bad bill may actually be enacted after years of waiting. The politicians may easily be miscalculating. Most seniors, who faithfully turn out to vote, want prescription-drug coverage through Medicare—not the private insurers that the GOP-controlled Congress and White House are pushing.

Further, an increasing number of Americans—32 percent today versus 16 percent in 1999—says that neither the Republican Party nor the Democratic Party is doing a good job on the issue of prescription-drug benefits for the elderly, according to a recent poll by the Kaiser Family Foundation and Harvard School of Public Health. The proposed congressional legislation can only deepen that sense.

Each bill would cost about $400 billion over 10 years and suffer from complexity and coverage gaps. Under the Senate bill, for instance, a senior would pay the first $275 in drug costs (the deductible), then half of the costs—up to $4,500. They would then get no benefit until the bills total $5,800 (an out-of-pocket expense of $3,700), after which 90 percent of the cost would be covered. Have you got that?

It gets worse. Beyond the deductible and co-payments, seniors would pay a monthly premium—even while getting no benefits when they are in the coverage gap. Although the premium is ''estimated'' at $35 a month, it's actually subject to a drug-cost inflator that, at the moment, is four times higher than inflation. It's also subject to interpretation by private insurers, who presumably would contract with the government to administer this plan—an uncertain assumption.

The Senate bill also provides for a ''fallback'': if a region doesn't attract two competing private insurers, the government may contract with pharmacy-benefit managers, firms that actually manage the prescription-drug programs of most large health-insurance plans. So why contract with the private insurers in the first place when these pharmacy-benefit managers have the expertise to drive down drug costs by leveraging Medicare's enormous volume-buying power?

That the pharmaceutical companies are trying to strip this fallback provision does indicate who wants the benefits here—and we're not talking about Medicare seniors.

The House GOP measure, indeed, has no fallback provision—which could leave large areas of the country without access to the Medicare drug benefit. It has the same premium problem and a bigger coverage gap. But it would provide more generous benefits: A $250 deductible and 80 percent cost coverage up to $2,000.

Neither bill offers the drug-price relief, simplicity and security that seniors need. But what do you expect from a Congress and White House that already have spent $1.7 trillion on tax cuts since 2001? Seniors, and critical Medicare and Social Security concerns, apparently only matter as talking points for an election year.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, I know the Senator from Arizona is here to speak. He will speak for 10 or 15 minutes, is my understanding.

We are at a point where we have very few amendments left. We have a couple that may take a little debate but I think most of them will be disposed of with minimal debate. I hope everyone understands we are moving this along as quickly as possible. The managers have worked for 2 weeks on this matter.

After the Senator from Arizona finishes his statement, we should be in a position to have a number of votes lined up for later this evening.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, the passage of the Medicare prescription drug benefits legislation is a difficult vote for me. It is unacceptable that in a country as wealthy as ours seniors across the country are struggling to afford the high cost of prescription drugs. I have supported adding a prescription drug benefit to Medicare because I believe no beneficiary should have to choose between life-sustaining prescription medications and other vital necessities. Far too many American seniors face those choices every day. Many ration their supplies of medication, skip dosages, or cut pills in half.

In Arizona, busloads of seniors depart from Phoenix and Tucson every week, heading south to Mexico to purchase lower cost prescription drugs. The story is similar across the northern border, where seniors make daily trips to Canadian pharmacies. Throughout the country, an increasing number of seniors are looking to online pharmacies, selling reduced-priced prescriptions imported from other countries, oftentimes with questionable safety.

That said, I also recognize, as does every other Member of Congress, that Medicare is on a fast track toward bankruptcy. The most recent Trustee's Report adjusted down the year Medicare will reach financial insolvency by 4 years, to 2026. Clearly, it is incumbent upon us to include comprehensive reform of the system in any Medicare prescription drug package in order to ensure that Medicare is financially sound for current beneficiaries as well as future generations.

Medicine has changed substantially since the creation of the Medicare system in 1965. Advances in medical technology and pharmaceuticals have led to more prescription-based treatments. The simple fact is, Americans now consume more prescriptions than ever before. In 1968, soon after the enactment of Medicare, American seniors spent about $65 a year on a handful of prescription medications. Today, seniors fill an average of 22 prescriptions a year, spending an estimated $999.

The bill before us represents one of the largest enhancements to Medicare since its creation, setting up an entirely new bureaucracy and establishing a sizable new entitlement program. I believe this bill addresses a real problem, the need to help struggling middle and low-income seniors. However, we must have no illusions. There are dangerous complexities and potential unintended consequences associated with this bill.

First, we must be realistic about the cost of this new entitlement program. For anyone who believes this bill will cost a maximum of $400 billion over the next 10 years, I have some oceanfront property in Gila Bend, AZ, to sell you.

Medicare and Social Security, together, represent an enormous unfunded liability for our Nation. In a few short years, millions of baby boomers will hit retirement age and the system will quickly become insolvent.

The numbers speak for themselves. Medicare currently has an unfunded liability of $13.3 trillion. Some have estimated the unfunded liability of the package before us in the $6 to $7 trillion range. A scholar at the American Enterprise Institute Scholar estimated that if passed, the Senate's prescription drug benefit legislation will result in a $12 trillion unfunded liability. Social Security and Medicare, with a prescription drug benefit, will together consume an estimated 21 percent of income taxes by the year 2020.

Long after the Members of this Congress and administration have left office, our children and our grandchildren, and a future Congress and administration, will be struck with the burden of cleaning up the mess we have created.

In the past 2 years, we have passed two large tax cuts. Government spending, however, has continued to increase well above the inflation use. Much of that spending is unnecessary, and represents a lack of fiscal discipline more common in times of federal budget surpluses. Yet our current budget deficit and national debt have risen dramatically. Security concerns in the post 9/11 era necessitate substantial increases in spending on defense and homeland security. We cannot sustain this level of fiscal profligacy indefinitely.

This extraordinary large new entitlement we are debating will impose an equally extraordinary burden on taxpayers. The money has to come from somewhere, and none of the ''somewheres'' are desirable. The reality is, this new benefit will be funded by raiding other entitlement trust funds, or by increasing our national debt, or by substantially increasing taxes.

Despite the enormous cost of this bill, this new entitlement will not provide the prescription drug coverage many seniors expect to receive. Nor does it enact significant reform measures needed to ensure the long-term solvency of the Medicare system.

Those seniors who think this bill will solve their financial problems will soon learn that there are substantial limitations to the benefit. When it does pass, the new prescription benefit will not be available immediately. In fact, it will take several years just to establish the new bureaucracy which will administer the prescription benefits.

Low-income seniors will benefit from this package, and I am pleased that they will. Many other seniors, however, will not receive a generous benefit, and might not even get out of the system what they will pay in deductible sand premiums. The Congressional Budget Office estimates that 37 percent of employers currently providing coverage to Medicare eligible seniors, will drop coverage if this bill passes. Last week, the Wall Street Journal quoted one analyst who called this bill the ''automaker enrichment act,'' because companies such as the automakers who currently provide their retired employees with a prescription drug benefit are unlikely to continue doing so if the Federal Government assumes part of the burden for them.

I am concerned that we are about to repeat—I emphasize repeat—an enormous mistake. I have been around here long enough to remember another large Medicare prescription drug entitlement program we enacted in 1988, Medicare Catastrophic. The image of seniors outraged by the high cost and ineffectiveness of that package should be a cautionary tale to all of us.

Moreover, I am not confident that the Medicare Advantage portion of this new scheme, which establishes regional PPO options for seniors, will succeed. Many in the insurance industry have expressed skepticism and concern that such plans will not be profitable. In the end, the Federal Government, which acts as a fallback if no private plans are available, might end up covering the majority of the country. Not exactly the reform we all had hoped for.

The American people should be aware that this new benefit has substantial cost to seniors, and to current and future generations of taxpayers, who will bear the majority of a crushing financial burden. There will be unintended consequences of our actions. We can be sure of that. Moreover, we should be honest about the cost of this measure—$400 billion is merely a down payment for what we are creating. Given the fiscal realities we face, realities that will become more dire with every passing year, Congress and the administration should have committed to addressing the acute need for a drug benefit to alleviate the impossible choices confronting lower income seniors. And, most importantly, begun to seek consensus among responsible Members of both parties for the reforms we all know are necessary to save Medicare.

I recently heard a good assessment of this package: it is ''an effort to do too much with too little, and thus doing nothing very well at all.''

There are several good amendments that have been adopted during this debate. I am encouraged that a bill Senator SCHUMER and I worked on for the last 4 years, might finally be enacted into law as part of this package. Our amendment will increase competition in the pharmaceutical industry and ensure that all Americans have access to lower cost generic drugs. That amendments, which would not have been possible without the leadership of Senator GREGG and the support of Senator KENNEDY, will reduce the cost to the government of any Medicare prescription drug benefit.

I was happy to cosponsor an important amendment with Senators FEINSTEIN, NICKLES, CHAFEE, and GRAHAM, which I believe will add some fiscal discipline to the bill and the Medicare program. The amendment will add means testing to Medicare Part B—increasing co-payments for wealthier seniors.

I am also pleased that several measures which I have supported and cosponsored as separate bills, have been adopted as part of this package, including the Immigrant Children's Health Improvement Act, the Blind Empowerment Act, and funds to reimburse hospitals for the uncompensated cost of caring for undocumented immigrants. Additionally, there have been several good amendments that I think will improve overall health care in our country. In particular, I believe Senator GRASSLEY'S amendment which requires agreements between brand and generic pharmaceutical companies to be reported to the Federal Trade Commission and the Justice Department will shine some much needed light on potential collusive agreements.

Despite these welcome improvements, and recognizing that this legislation will address the crisis faced by lower income seniors, the costs of this entitlement remain, simply put, beyond the means of this country absent real reform of Medicare. Therefore, after much thought, I regret that I cannot vote for this legislation. I have reached this conclusion, not because I believe our seniors and disabled do not need or deserve prescription drug coverage, but because I do not believe our country can sustain the cost of this benefit, which will not, despite it's staggering expense, provide the assistance many beneficiaries will expect.

As I noted, Congress and the administration should have addressed the acute need for assistance of lower income seniors. And before we consider extending that assistance to other seniors, we should save Medicare first by instituting the reforms we all know are necessary, but which we apparently prefer to defer until we have retired from public service. I know that those reforms pose a very difficult political challenge to us, and that the bipartisanship we have commended in the drafting and consideration of the legislation before us today would be put to a far more severe test should we genuinely attempt to save the Medicare system from insolvency. However, should we simply add another huge, new unfunded liability to an already fiscally unsound entitlement, imposing a breathtakingly heavy tax burden on our children and their children, with devastating consequences for their prosperity and the national economy, we will have done the one thing no public servant should want to be remembered for, we will have left the country worse off than we found it.

I yield the floor.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. ALEXANDER). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, the Senator from Michigan, Mr. LEVIN, has been extremely patient. He has been waiting for us to get a unanimous consent for his amendment. We are very shortly going to get that, but prior to that being announced, the Senator from Michigan is going to offer amendment No. 1111. He is going to speak for 10 minutes. Senator STABENOW will speak for 5 minutes, and Senator GRASSLEY and Senator BAUCUS will speak for up to 10 minutes in opposition, if they need to. The leaders will arrange a vote at some time that they have agreed upon.

I ask unanimous consent that that be the case.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Michigan.

AMENDMENT NO. 1111

Mr. LEVIN. Mr. President, the amendment which I will be offering is designed to ensure that the CBO estimate of 37 percent of current retirees who now get their prescription drug coverage from their former employer and who will lose that coverage as a result of this bill will at least have the option of a prescription drug coverage under the Medicare fallback.

There are a number of problems which have been identified with this bill. Some of them are significant problems which cause many of us, who very much favor having a prescription drug benefit available to our seniors, great pause before we support this bill. For instance, there is a so-called yo-yo effect in this legislation. Some have called it the revolving door effect. The problem there is that seniors who are offered two private plans in their service area must pick one of those private plans. They cannot use the Medicare fallback. There will not be a Medicare fallback with a guaranteed premium because if two or more private companies offer a prescription drug program, with whatever premium they decide upon, then the seniors in that service area must pick one of those two private plans.

What happens then if the senior says, okay, I am going to pick that private plan A, and then a couple of years later the private sector decides to pull out of that service area? At that point, the senior will be offered the Medicare fallback.

Then what happens if the private insurance folks decide to come back into

that service area? Could the senior keep the Medicare fallback plan? No. They are kicked out of that plan even if they want it. They have to go into one of the private plans again. Then that can be repeated over and over again. Each time private insurance companies decide to pull out of an area, the seniors then can get into a Medicare fallback, but when private companies come into the service area again, they are removed from the Medicare Program and have to go back to one of the plans. It is confusing, uncertain, unfair. It is the yo-yo effect, what others call the revolving door. It is a real problem with this plan. We ought to give much more certainty to that.

Another problem identified is the so-called donut hole problem. We have heard quite a bit about that problem where once a senior is told her drug spending reaches $4,500 for a year, she will have to pay 100 percent of the costs of the prescriptions until the total drug spending reaches $5,800. Now, premiums will continue to be paid during that period, but the gap in coverage will be there, so from $4,500 to $5,800. There is not a 50/50 deal between the plan and the senior; it is 100 percent burden of the senior during that period. That is a real gap in coverage. That is a gaping hole in coverage. I don't know of any other insurance program that is so unfairly structured. That is another problem which has been identified. There have been efforts made to correct that, without success.

Another problem identified is that the private insurance plans that may come into a service area do not have a cap on the premium; it is an unlimited premium. That is a problem which has been identified. The effort to put a cap on the premiums has failed.

But of all the flaws that have been identified, the weaknesses in this program, the one that troubles me most and that troubled seniors most is the fact that it has been estimated by the CBO and by the Health and Human Services folks who operate Medicare that 37 percent of current retirees who have a prescription drug program through their former employer are going to lose their prescription drug benefit following the enactment of the plan before the Senate; that is, a situation where we are actually going to see 37 percent of our seniors—that is the estimate—who currently have a benefit being worse off as a result of what we do.

There is a debate here as to whether the plan before the Senate is going to be good for seniors because of the donut hole or because of the fact there is no cap on premiums or because of this yo-yo effect, this revolving door effect. Is it a good plan? Is it not a good plan? Will seniors who don't have health insurance, a prescription drug program now, actually want to opt into this program? That people can debate. But, at a minimum, we should do no harm. At a minimum, we should not have millions of seniors who will lose an existing prescription drug program as a result of our enacting a plan. That is the time bomb in the bill before the Senate. We should not leave people worse off than they otherwise would be.

During the markup of this bill, we had some experts who testified. One was Tom Scully, Administrator of the Centers for Medicare and Medicaid Services at HHS:

Among employees who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped.

A little later on, page 6 of the transcript of the markup of the Finance Committee:

TOM SCULLY: Thirty-seven percent of those retirees who have employer-sponsored coverage . . . [will lose their coverage].

Then, a little later on in the markup of the Finance Committee, Senator CONRAD was going to ask a question of Mr. Holtz-Eakin, our CBO Director, about this issue, and the majority leader posed a question.

Senator FRIST: Senator CONRAD, could I—on that last—I'm over here—on this employers dropping it, can I just ask a follow-up question just real quick.

Senator CONRAD: Yeah. Absolutely.

Senator FRIST: You said—is it 37 percent of employers are going to drop——

TOM SCULLY: Yes.

Colleagues, Senator FRIST said something which I hope will reverberate in this Chamber.

Senator FRIST: This has huge implications.

Then the Director of the CBO said the following:

Mr. HOLTZ-EAKIN: Thirty-seven percent of employees—of retirees with such employee insurance.

Then there was a voice, unidentified by the reporter:

MALE VOICE: As I understand it, this 37 percent is the effect of our legislation.

Mr. HOLTZ-EAKIN: Correct.

Colleagues, Senator FRIST is correct. This has huge implications. And we ought to address it. The least we can do is to direct Health and Human Services to make available to designate a Medicare backup plan for the 37 percent of our current seniors who have a prescription drug program through their previous employer to make available to them the Medicare backup program so they at least know there will be a Medicare backup for them if they lose their current prescription drug program, as is projected by the Congressional Budget Office and by Health and Human Services. It seems to me that is the least we can do.

It still will be harmful because it is very unlikely for most of the people that the Medicare backup will be as good as their current prescription drug program. It is unlikely. But at least we can say, for those people, there will be a Medicare backup plan designated by HHS which will have the criteria established by HHS and the premium established by HHS. That is the least we can do for those who are going to lose their prescription drug benefit that they currently have following the enactment of this legislation.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator has 1 minute 15 seconds.

Mr. LEVIN. I reserve the remainder of my time.

I ask unanimous consent to call up amendment No. 1111.

The PRESIDING OFFICER. The amendment is pending.

Mr. LEVIN. I ask unanimous consent that my colleague from Michigan, Senator STABENOW, be listed as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEVIN. I ask unanimous consent that the excerpts from the quoted testimony be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Senator ROCKEFELLER. Okay. Actual dollars in the plan that are spent on, number one, the drug benefit itself, provider add backs and that's all I can see. I don't need the third one I've written down.

TOM SCULLY. These are figures that were in the table. We issued it to the Committee. Since this table was put together, there were some modest modifications to the drug benefit. In particular, putting the cap at $4,500.00 instead of $4,725.00. That changes the estimate on the drug benefit from $408 billion to $402 billion over ten years.

Senator ROCKEFELLER. Four hundred two?

TOM SCULLY. Four hundred two. Six billion dollars lower. And, the provider add backs are listed on pages 2 and 3—or, pages 1 and 2——

Senator ROCKEFELLER. Could you give them to me?

TOM SCULLY. There's a long list of them, and simply adding them up is not that—they interact in many ways.

Senator ROCKEFELLER. [Unintelligible].

TOM SCULLY. [Unintelligible].

Senator ROCKEFELLER. Next one is, percent of employers who drop retiree coverage. And, the number and percent of beneficiaries who will lose retiree coverage under this plan so far.

TOM SCULLY. We don't have an estimate of the number of employers. But, among employees who have employer-sponsored insurance, our estimate is consistent with 37% having their coverage dropped. Of that 37% of those who have such coverage, about 11% of beneficiaries overall.

MALE VOICE. Could you repeat that? I didn't get the—you might pull the microphone up a little closer to you.

TOM SCULLY. Thirty seven percent of those employees who have employer-sponsored coverage, it's 11% of beneficiaries overall.

Senator ROCKEFELLER. And, what percent would drop it?

TOM SCULLY. We don't know the number of employers who would drop coverage. We know the number of employees who are effected.

MALE VOICE. I thought you gave an estimate—excuse me—this is Senator Rockefeller's time, and I just want to make sure I——

TOM SCULLY. Let me repeat so it's——

MALE VOICE. Just repeat what you said.

TOM SCULLY. Underlying our estimate are that 37% of employees who have beneficiaries who have employed-sponsored insurance, retirees who have such employer-sponsored coverage, 37% will lose their coverage. And, that is 11% of total beneficiaries.

MALE VOICE. Could I also add into this, Senator Rockefeller? What we also need to know is, what percentage of the figure you said might drop—or, case would be dropped even

Or, they could drop it entirely.

In those latter two cases, they can use the additional resources to provide other kinds of employee compensation.

What we've done is examine the literature to the extent that we can find it on employer responses to the shape of compensation packages in shaping our estimate of the number that would drop.

Senator CONRAD. Okay. Let me go to something that I have found difficult to follow. And, I'd like, if I could, to have the attention of the Chairman.

Senator FRIST. Senator Conrad, could I—on that last—I'm over here—on this employers dropping it, can I just ask a follow up question just real quick.

Senator CONRAD. Yeah. Absolutely.

Senator FRIST. You said—is it 37% of employers are going to drop——

TOM SCULLY. Yes.

Senator FRIST. This has huge implications.

Mr. HOLTZ-EAKIN. Thirty seven percent of employees—of retirees with such employee insurance.

Senator FRIST. Okay.

Mr. HOLTZ-EAKIN. And, that's 11% of overall Medicare beneficiaries.

MALE VOICE. Okay. If we did nothing, how many would be dropped over the next ten years? If you look at these curves, the employees—yours are getting out of the business, anyway—not out of the business, but the curve is going down.

What would it be ten years from now?

Mr. HOLTZ-EAKIN. We don't have an estimate of that. We isolated our estimate on the impact of the bill above the baseline. That's a question about the baseline estimate, and I don't have that.

MALE VOICE. Okay.

MALE VOICE. It's 37%, just so we're clear with each other. As I understand it, this 37% is the effect of our legislation.

Mr. HOLTZ-EAKIN. Correct.

MALE VOICE. I think the question Senator Frist has is, in your baseline you have an assumption that there will be changes, though, correct? Or, don't you?

Mr. HOLTZ-EAKIN. No, we do not.

MALE VOICE. And, would you suggest that that's an inaccurate baseline?

Mr. HOLTZ-EAKIN. In reality——

MALE VOICE. Its reality is not that. And, I can have a few of my retirees in Pennsylvania give you a call if you have any questions on that subject.

I mean, I think that's an unfair—I mean, baselines are supposed to be real, but not supposed to be artificial. That's artificial.

Mr. HOLTZ-EAKIN. The baseline issue that we—that is most important, that we capture is new retirees not having such coverage.

This is a provision that would induce existing retirees who have such coverage to have their coverage dropped or modified by the their employer.

MALE VOICE. I understand what this provision does. I just want you—I just want an understanding of what would happen without this being calculated into the baseline.

MALE VOICE. Senator Santorum, we've looked at the literature and the surveys of the employee benefits consultants of retiree offerings.

What we understand is mainly happening is that, for current workers who are newly hired, they are—employers are no longer putting as part of their compensation package a guarantee of retiree healthcare.

As far as we can tell, the base of people who are near retirement or retired are not having their healthcare—there's not that much erosion going on.

MALE VOICE. I'll have the people from Bethlehem Steel and about seven other steel companies in Pennsylvania that I can just think of off the top of my head give you a call, and let you know that their retiree health benefits have been eliminated. I mean, it's happening all over the place.

Senator Rockefeller, would you like to join into this? I mean—so, I just—I think you need to look at your baseline, please.

And, then give us an understanding of maybe looking back over the last few years and projecting forward given the trends what—how the baseline would be affected. And, I think that would much—be a much fairer score as to what the impact of this bill would be.

Senator CONRAD. Mr. Chairman?

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Let me just say that I agree entirely with Senator Santorum. We know that people are dropping—employers are dropping their plans.

And, I understand your answer to this question is the effect of this bill.

I think one of the things we've got to do—Senator Frist said it well—this has got major implications; 37% having their healthcare plans dropped. That means it's going from being on the company's nickel to being on our nickel; that dramatically increases the cost.

So, if we can find ways to hold that number down, that's in our interest and we should pursue it.

Let me go——

Mr. HOLTZ-EAKIN. If we could, before we——

Senator CONRAD. Yes, sir.

Mr. HOLTZ-EAKIN. I understand the policy interest, and * * *.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I am very proud to be joining with my colleague on this very critical amendment. Can you imagine, you are someone who has worked hard all of your life, you have been fortunate enough to have a good-paying job with benefits, you are now retired and you are fortunate to have good health benefits and you find yourself in a situation that, as a result of an action taken here—and certainly there is an effort to move forward and provide people with prescription drug coverage—but if those who already have coverage find, as a result of an action we take, there is an incentive for their employer to drop their coverage, how would you feel about that?

I know how I would feel about that. This amendment is about making sure those who have worked hard all of their lives, who have retired and have had the confidence and the security to know that those health care benefits, retirement benefits they have worked so hard to have in their retirement, would be secure—to make sure if someone is covered right now for prescription drugs that he or she not lose the ability to continue, at least to know that if their employer changes their benefit, they would have immediately the security of the backup Medicare prescription drug plan.

This is very critical in a State such as Michigan where we have 37 percent of our retirees who have insurance, who right now are fortunate enough to have health care insurance and prescription drug coverage.

While there are positives in this bill so there are those who will receive help as a result of being low-income seniors, or those with very high prescription drug costs who will receive help under this bill, one of the glaring omissions and great concerns that I have relates to what Senator LEVIN was just speaking about, the unfairness of saying to a group of people who have been fortunate enough to have insurance and prescription drug coverage that, as a result of something done by the Congress, they would potentially lose that coverage. That makes absolutely no sense.

What our amendment is saying is if, in fact, their employer would have the incentive to change or drop their coverage, they should be guaranteed that something else is right there, that Medicare as a backup should be there.

My preference would be that we change the formulas so there is not the incentive to drop anyone. That was one of the reasons I strongly supported Senator ROCKEFELLER's amendment and other amendments that have been on the floor. Because my first choice is we take away any incentive for anyone to lose their prescription drug coverage. But unfortunately those amendments were not successful. We did not have the support to do that here.

Given that, we are now coming in and saying if, in fact, an employer, because of the incentives, makes a determination to drop coverage, that at a minimum, out of a sense of decency and fairness, at a minimum that retiree needs to know that Medicare prescription drug coverage, through Medicare, is available without wading through tons of insurance forms or picking through plans or going through all the ups and downs that have been described so many times in this Chamber. They need to know, after having coverage, having it available, having it dependable, that another plan is right there for them. That is the least we can do.

I hope we will join together in a bipartisan way this evening to agree to this very important amendment, and let us send a message to those fortunate enough to have health care insurance and prescription drug coverage that we remember them, we care about them, and we are going to make sure no harm is done to them in the process of putting together this prescription drug plan.

I yield the floor.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, this is the greatest and most prosperous Nation in history. Nobody has worked harder to make this country great than our senior citizens. And few things weigh more heavily on their minds than the soaring cost of prescription drugs.

You would think such a great, prosperous Nation would honor its elders, by making sure they get the medicines they need. That is why a comprehensive, meaningful and voluntary drug benefit for our senior citizens has been among my highest priorities.

Over the last several weeks, this Senate has worked hard to achieve that. In the process, many of us who shared that goal have disagreed about how to react it. In the end, we wound up with a bill that is not how I would have created a prescription drug benefit. But it is a start.

I am voting for this bill, because I believe some benefit is better than none. I am voting for it because of people like Shirley Rosamond of Sparks, NV. Shirley, who is 78 years old, raised eight children in the Sierra Nevada. She currently spends $400 a month on medicine, and has less than $400 left over to live on. This bill would reduce her monthly costs to less than $20 in medicine. And it would provide a similar level of assistance for tens of thousands of Nevada seniors.

I am voting for this bill in the hope it will be like the camel's nose under the tent—a foot in the door for our senior citizens.

I'm hoping we will pass this bill today, and then improve it in the future. And, yes, there is plenty of room for improvement.

For example,this bill will do little to help seniors whose income is $15,000 a year or more. Even if they spend more than $100 a month on prescription drugs. That is why I voted to make the program more generous.

This bill doesn't take effect soon enough. That is why I voted for and cosponsored the Lautenberg amendment to move the start date up to 2004, instead of 2006.

There are gaps in the coverage this bill provides. That is why I voted for Senator Boxers' amendment to close the coverage gap, and Senator Graham's amendment to cancel premiums while coverage is suspended.

There were other amendments that were very good but were not agreed to. Finally, this plan is just plain confusing—which means it won't give our senior citizens the peace of mind they deserve.

I voted to address all of these issues. I wish we had succeeded, and that this bill would provide the kind of coverage our senior citizens need. We didn't and it doesn't.

We have to be honest with our senior citizens, and with the American people. This isn't the best we can do for our senior citizens, but it is the best we can do tonight.

I will vote for this bill today, because it provides a start toward fulfilling our promise to senior citizens. It a start, and I won't stop fighting until we finish the job.

The PRESIDING OFFICER. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I know we are waiting for some completion on negotiations on an amendment. As I understand it, no one is seeking recognition to continue work on other amendments. So I will speak for a couple of minutes until somebody is prepared to come to the floor to continue our work. I don't want to delay the business of the Senate but I want to express myself, as the distinguished Democratic whip has been doing with regard to the legislation.

I, too, intend to support this bill. I am thinking of the old joke about a camel being a horse designed by a committee. Oftentimes, I think of that as we work our will on legislation. In many respects, this is the legislative version of a committee horse, a camel.

It is not the kind of bill I would write. It is not the kind of bill I would cosponsor. It is not the kind of bill I would enthusiastically endorse.

I look at some of the concerns we have about this legislation—concerns about an unlimited volatility in the premium, uncertainty about the benefit package, uncertainty with regard to the deductible, uncertainty with regard to the backup, uncertainty with regard to the way the provisions can be provided in rural areas. There are many issues. Mostly I think there is far greater confusion than there is understanding with regard to the benefits themselves as seniors attempt to determine whether they will be assisted by this bill.

The confusion and the uncertainty will be issues that we have to address at some later date. But having said that, I must say that the rural provisions—the effort made by our two distinguished managers to address the rural needs to overcome the inequities that exist today—alone merit consideration and I would suggest support for this legislation. The help for low-income seniors—tens of thousands of South Dakotans will get help they are not getting today in part because of this bill. The possibility that seniors could access generic drugs with far more regularly and successfully, and the possibility that we could reimport drugs at a lower price from Canada, all are reasons why I think this bill merits our support.

As I look to the balance and look to all of those things I wish were better, my response is that we are going to make them better. It may take months, if not years, but we are going to continue to work to make this a better bill and a better program.

There are so many ways that I hope we as Senators—Republican and Democrat—can work together to make this a better bill in future years.

There is a warning and a hope as we complete our debate tonight. The warning is that if this legislation comes back from conference in a significantly different form we will not be in the same position we are tonight. This bill will enjoy broad bipartisan support tonight. But if we fail, if we endorse a bill with some of the provisions of the House, then I daresay this legislation may still be in trouble.

My hope is that we can do what I have just suggested—that over the course of the next several years we can take a very close look at ways to make this legislation better and that we can address what I would consider to be serious shortfalls, especially the benefits shutdown that exists after a person pays $4,500. We are talking about a sickness penalty that, frankly, cannot be sustained. We have to find a way to address that serious shortcoming in this legislation. I hope it is done sooner rather than later.

I come to the floor with my gratitude for the work that has been done. This is the fifth year we have made an effort to pass meaningful prescription drug legislation. We can wait no longer. We simply can't allow the perfect to be the enemy of the good. We have to take what we can do and move to build upon something that we will do in future years to make it more meaningful, make it a better piece of legislation, and make it a law that we can be enthusiastic about someday.

I vote tonight with that expectation and that hope. I am hopeful that there will be many on both sides of the aisle who will share that perspective and that expectation.

I yield the floor.

Mr. FRIST. Mr. President, I ask unanimous consent that at 9:15 tonight the Senate proceed to a vote in relation to the Levin amendment, No. 1111, to be followed by a vote in relation to the Hagel-Ensign amendment, No. 1026, with no second degrees in order to the amendments prior to the votes and with 2 minutes of debate equally divided prior to each vote.

I further ask unanimous consent that prior to the vote Senator ENSIGN be recognized for up to 15 minutes and Senator HAGEL, for up to 10 minutes, and the two managers be given up to 5 minutes each; further, that it be in order for the Hagel-Ensign amendment to be modified up to the beginning of the stacked votes.

The PRESIDING OFFICER. Is there objection?

Mr. DASCHLE. Mr. President, reserving the right to object, I suggest that we make them perhaps 10-minute votes as well to expedite our votes.

Mr. FRIST. Mr. President, let us make it 10-minute votes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Nevada.

AMENDMENT NO. 1026

Mr. ENSIGN. Mr. President, I rise to speak on behalf of the amendment on which Senator HAGEL and I have been working actually for the last several years. This amendment received bipartisan support in the last Congress as a

stand-alone bill. We actually made some improvements to it. We think if this amendment is adopted, it will dramatically improve what the committee has attempted to do to add a prescription drug benefit to Medicare. The only portion of the bill we are modifying in substantial form is the prescription drug part of it.

Let me talk about what our amendment exactly does. It would say to a person who is below 200 percent of poverty, they would pay the first $1,500 out of pocket. After that, the Government is going to pay for the rest of their drug costs, other than a 10-percent copay the person would pay.

However, if a person is up to 160 percent of poverty, we will give them, in a pharmaceutical benefit account, $500 per year, which they can use to go to a local pharmacy to buy their prescription drugs or they can use that money and negotiate the price of their prescription drugs through a pharmaceutical benefit manager and mass buy them with their drug discount card. If they want to use their local pharmacist, they can do that. And this $500, if they did not spend it that year, would be rolled over to the next year where it would cover the first part of their deductible. So if you are below 160 percent of poverty, the most you are going to pay out of pocket is less than $100 per month.

There are several benefits to our plan. First of all, with the committee mark, you pay a monthly premium of $35. You also have a deductible of $275. With our bill, you have no monthly premiums, you have a one-time annual fee of $25, and for low-income people, we waive that.

Our plan is completely voluntary. It also gives the most help to lower income seniors and gives progressively less help the more money you make.

So between 200 percent and 400 percent of poverty, $3,500 is your out-of-pocket expenses. Above that amount, the Government pays 90 percent. And from 400 percent to 600 percent of poverty, $5,500 is your out-of-pocket expenses. Above that amount, 20 percent is your deductible before catastrophic coverage kicks in.

For all of these people, though, who want to sign up for the plan, they get a drug discount card where they will save between 25 to 40 percent on their prescription drug costs. It is a completely voluntary program. And in this program, we have several benefits that we think are better than the committee's underlying bill.

One is, under our bill, States that have already enacted programs will be encouraged to keep their programs. Under the committee mark, every State that has a program for low-income seniors is going to drop those. There is no debate about that. As a matter of fact, the Secretary of HHS was before us. The person who oversees Medicare was before us. Both of them said there is nothing in this bill that will say to the States: Don't drop your plans. And they agreed they will probably drop their plans.

Our bill works with the States that have those programs, States such as my State of Nevada, and encourages those programs to be kept.

A couple of other advantages that our bill has: I want to illustrate those with a couple of examples. These are real-life cases. This is a fictitious name, of course, to protect this woman's identity, but this is a real person. We call her Doris Jones. She is 75 years old. She has an income of about $17,000 a year. She is being treated for diabetes, hypertension, and high cholesterol. She is taking medications that are very typical of what this type of a disease management would require. Her out-of-pocket expenses right now are $3,648.

Let's compare how our amendment, the Hagel-Ensign approach, would affect her out-of-pocket expenses versus the bill on the floor if our amendment is not accepted.

Under our bill, she would have $1,700 out-of-pocket expenses a year. Under the committee bill that is before us today, she would have $2,383 a year. So it is a savings of almost $700 under our approach.

Another person: James is 68 years old. He has an income of about $16,000 a year. He is being treated for diabetes, a pretty severe case of diabetes, and he has all these different medications—very common medications today for a diabetic. His total out-of-pocket expenses today are $5,700.

How does he compare under the two provisions?

Under the Hagel-Ensign approach, about $1,900 would be his out-of-pocket expenses for the year; under the bill that is before us today, a little over $4,000 in out-of-pocket expenses a year. So the difference is almost $2,200 to this senior who is sick. And we certainly would not call him a rich person. I would call this person certainly a low- to moderate-income senior.

Now, Betty is another example. These are real-life examples taking real medicine, prescribed by real doctors. She is 66 years old. She has an income of $15,500. She is being treated for breast cancer and she is taking commonly prescribed medications for that. She is on low-dose radiation. She pays about $8,000 for her prescription drugs a year.

What would happen to her under the two different scenarios?

Under our scenario, she would pay about $2,100 out of pocket. Under the bill that is before us today, she would pay $4,300.

What we have done with our amendment is we have said: Let's help the seniors who need it the most. And we put the dollars to them. Under our amendment, people who are sick, with low and moderate income, they really get help. For people above that, they are treated about the same between our amendment and the bill. The out-of-pocket expenses for people between 200 and 400 percent of poverty are about the same.

When you start getting to the wealthier seniors, there is no question, the committee bill is more generous. For very low income seniors, the committee bill is slightly more generous. But for those who are really sick, our amendment is much better.

Also, there are a couple of other advantages.

In the future, to control costs, our amendment says: The person receiving the medication has something at stake. They are paying out of their own pocket for the first dollars, so they are going to shop. They are going to go around and see: Do I need generics? First of all, do I need the drug? Could I take a generic, which may be less expensive? Are there perhaps other alternatives for treatment that may be cheaper and just as effective? They will have that conversation with their doctor because they have something at stake.

I would argue that what the committee is doing—and I applaud what they are doing, trying in a bipartisan fashion—I believe our amendment would strengthen the committee's bill dramatically because it would target the dollars, those precious taxpayers' dollars, to the people who need it the most. It will also, though, in the future, control costs and, therefore, be more responsible to the next generation.

The committee mark, especially for very low income people, pays 97.5 percent of their drug costs, maybe a $1 to $2 copay. Well, there is going to be a tremendous amount of overutilization in that group.

Our amendment gives that group help by putting $500 of their first costs into an account. They will use that to go shop because if they do not use it, it gets rolled over to the next year where it covers more of their deductible. So they have something to benefit by if they do not use it.

So I implore our colleagues to look and compare. If you look and compare, you will see there truly is a difference.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I commend Senator HAGEL and Senator ENSIGN because they have been working very carefully over the last few years to help move this process along. They have had a different approach than I have had. I have had what I call a comprehensive, universal, voluntary approach. They have

had one that is more targeted toward low-income people and toward catastrophic. We deal with that in our legislation, but we are very comprehensive. We are very universal. I don't attack their attempt, but it is just not as good as what is before the Senate. S. 1 already reflects the influence of their plan by providing a drug discount card which will give seniors access to discounted drug prices.

I would like to point out a few things. The Hagel-Ensign plan has two laudable objectives: to protect seniors against catastrophic costs and to ensure that low-income seniors are fully protected.

I am happy to report that S. 1 already meets these goals. S. 1 provides a generous protection for low-income beneficiaries, very generous. It also covers fully 90 percent of beneficiaries' out-of-pocket costs beyond $3,700. Most seniors don't have catastrophic drug costs and thus would not see any benefit from the coverage in the Hagel-Ensign plan. S. 1, on the other hand, would provide a significant basic benefit to most seniors each year. Passing a drug bill that most seniors would see no benefit from is a prescription for disaster. I am afraid of that.

So S. 1 already meets the main goals of the Hagel-Ensign plan, but it provides additional value to a much broader group of beneficiaries as well, the underlying bill, the one that they amend, the one they would decimate.

Another thing S. 1 does very well is use competition to maximize value to the taxpayers. There has been some concern that S. 1 doesn't have as much competitive reform as many of us would have preferred. But the Hagel-Ensign plan has far less reform and is much more government run.

I would like to explain: First, this amendment would rule out any true competition in the delivery of Medicare drug benefits. S. 1 would let private drug plans assume a modest amount of financial risk, giving them an incentive to drive hard bargains and keep taxpayers' costs down. It seems to me that is very significant—the difference between the underlying bill and their bill. We are going to drive drug prices down more through competition.

The Hagel-Ensign plan, it is pretty obvious from my point of view, allows for no such exemption, specifically mandating that the Government—in this case we are talking about the taxpayers—bears all the financial risk for delivering the benefit, much as Senator BOB GRAHAM's did the last year when we debated this very issue.

Under this amendment, the benefit would be delivered just like other Medicare benefits are today—by contractors that merely pay the claims that come in without any effort whatsoever, no effort to contain costs.

Second, the Hagel amendment doesn't include any of the improvements to the Medicare Program that President Bush has proposed and our bill includes. It does not include the role for private preferred provider organization plans to deliver an improved Medicare benefit package. It doesn't make modern innovations such as disease management services or rational cost sharing available to beneficiaries who choose them. It simply dumps a catastrophic drug benefit on to the 1965 vintage Medicare system.

What the people of this country need is improvement in Medicare, strengthening of Medicare, voluntary, universal, comprehensive. The Ensign plan wouldn't improve S. 1, but it would make it substantially worse.

I urge my colleagues to defeat the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I want to clear up something. We don't touch any of the other Medicare reforms in your bill. The whole thing with the PPOs, we touch the prescription drug part of the underlying bill.

You mentioned competition. I practiced veterinary medicine, built, owned, and operated two different animal hospitals. Why do I bring that up? It is because in veterinary medicine people pay out of their own pocket. Veterinarians are in an incredibly competitive field because we know that if somebody brings a case to you, they are going to shop about half the time based on price. So veterinarians have to be very competitive and price sensitive to that, so they work to become more efficient, to keep their costs down, because individuals shop.

In our health care system today, individuals do not shop because we have low deductible policies, and a lot of times the doctors waive those deductibles. Senator FRIST will be able to tell you about that. The hospitals waive the deductibles. So the person receiving the care is not accountable for the care, and so they don't shop. The doctor tells them, go get this service or this drug, and they don't think about it. They have modest, low copays, and they don't think about it.

The cost control, the competition, is established by 40 million people on Medicare, 40 million people receiving drugs. If they are paying out of their own pocket or low-income people have the $500 in a pharmaceutical benefit account, they have something at stake, so they go shop.

They ask the questions: Do I need the drug in the first place? Maybe I can get a generic. So they do the shopping. Also, we have pharmaceutical benefit managers in the bill. That is what the whole drug discount card is about. So those pharmaceutical benefit managers help lower the costs as well.

We have several reforms in this bill that are true reforms, that introduce competition to keep the costs down. That is why our bill actually scored lower.

Because of that, we were able to add a couple other things. When Senator HAGEL arrives, he will modify the amendment. For instance, we will allow Medicaid, the dual eligibles that people have been talking about today, to give States help in handling those dual eligibles through Medicare because our prescription drug cost to the taxpayer was less. It is because we have more reform on the prescription drug part of it than the underlying bill. It just a difference of philosophy of how you do it.

I come to this based on my experience in the private sector and how health care can be delivered by individuals shopping.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time be equally charged.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HAGEL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HAGEL. Mr. President, in the last 2 weeks the Senate has engaged in an historic effort to reform and strengthen Medicare. When we opened this debate 2 weeks ago, I said that what we would do here debating this bill would affect every American and future generations.

Health care is a defining issue for our Nation and future generations. Just a reminder: When Medicare was enacted in 1965, the Federal Government's lead actuary at that time projected that the hospital program, Medicare Part A, would grow to $9 billion by 1990. In fact, the program, in 1990, had then cost the taxpayers $66 billion. So we have some sense of how these programs can get out of hand if not defined clearly at the front end.

In addition to the internal problems of the changing realities of health care, Medicare is facing a looming external problem. The largest generation in American history, the baby boomers, are aging. These Americans—over 75 million of them—will be added to the Medicare rolls over the next few years. The baby boom generation has changed and shaped every market it has ever entered. Medicare will be no exception. We have a responsibility to address this demographic pressure now or risk the system collapsing under its own weight in the future.

Senator ENSIGN and I have come to the floor to offer an amendment to substitute only title I of the Finance Committee's bill, providing a prescription drug benefit for seniors. We believe any Medicare drug benefit must be sustainable for future generations. The benefit must deal with the realities that people are living longer and better and have higher health care expectations than ever before. We believe we can do better with our amendment.

Our amendment is a simple amendment. Seniors will be able to understand it clearly. Unlike the underlying bill, our amendment contains no premiums, no deductibles, and no gaps in coverage. Our modified amendment addresses three of the major issues we have tried to deal with in constructing this plan. First, it helps low-income seniors, those who need it the most. Two, it protects seniors from high out-of-pocket expenses, and it eases the burden prescription drug costs have placed on the States.

Our modified amendment would replace the prescription drug benefit in the Finance Committee plan with, No. 1, a prescription drug discount card for all seniors on Medicare with $30 billion in added funds for low-income seniors; No. 2, catastrophic coverage for all seniors; No. 3, $35 billion in cost-sharing for catastrophic drug costs with the States for the lowest income seniors eligible for both Medicare and Medicaid.

We give the Secretary of Health and Human Services the discretion to divide $65 billion for seniors and for help with drug costs at the State level. With our amendment, the Secretary will provide low-income seniors with money on a drug discount card to help defray their drug expenses.

States would also benefit under our amendment, and $35 billion is available to help States cover the catastrophic drug expenses for the dual eligibles. These are the very poorest of seniors.

These modifications to the amendment make it stronger by targeting aid to those who need it the most. This bill has been scored. We fall within the $400 billion budget number that is required.

This is a commonsense plan that is workable and responsible, and it addresses prescription drug concerns in the right way.

AMENDMENT NO. 1026, AS MODIFIED

Mr. HAGEL. Mr. President, I have a modification at the desk to amendment No. 1026. I ask unanimous consent that the amendment be modified.

The PRESIDING OFFICER. The amendment is so modified.

The amendment (No. 1026), as modified, is as follows:

TITLE I—MEDICARE PRESCRIPTION DRUG DISCOUNT

SEC. 101. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D(a)(4)(B).

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered drug—

''(i) for which payment would not be made if section 1862(a) applied to part D; or

''(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D(a)(4).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

''(A) eligible for benefits under part A or enrolled under part B; and

''(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

''(A) pharmaceutical benefit management company;

''(B) wholesale pharmacy delivery system;

''(C) retail pharmacy delivery system;

''(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

''(E) Medicare+Choice organization;

''(F) State (in conjunction with a pharmaceutical benefit management company);

''(G) employer-sponsored plan;

''(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

''(I) combination of the entities described in subparagraphs (A) through (H).

''(4) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

''ESTABLISHMENT OF PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

''(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

''(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

''(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

''(c) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''ENROLLMENT

''SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

''(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

''(2) ENROLLMENT PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

''(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

''(C) OPEN ENROLLMENT PERIOD IN 2005 FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

''(i) enroll under this part; or

''(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

''(3) PERIOD OF COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

''(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(4) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

''(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual's coverage under this part if the individual is—

''(i) no longer enrolled in part A or B; or

''(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

''(i) the termination of coverage under part A or (if later) under part B; or

''(ii) the coverage under title XIX.

''(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

''(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

''(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

''(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

''(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

''(3) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

''(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICARE+CHOICE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a Medicare+Choice plan.

''(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(F) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

''(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

''PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

''SEC. 1860C. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

''(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860B(c).

''ENROLLEE PROTECTIONS

''SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

''(1) GUARANTEED ISSUANCE AND NONDISCRIMINATION.—

''(A) GUARANTEED ISSUANCE.—

''(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(ii) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

''(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(2) DISCLOSURE OF INFORMATION.—

''(A) INFORMATION.—

''(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

''(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

''(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

''(II) How any formulary used by the eligible entity functions.

''(III) Information on grievance and appeals procedures.

''(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

''(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

''(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the

information described in paragraph (3) to such beneficiary.

''(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

''(3) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

''(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(4) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

''(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

''(1) ACCESS TO COVERED BENEFITS.—

''(A) ASSURING PHARMACY ACCESS.—

''(i) IN GENERAL.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(a)(3) that ensure such convenient access.

''(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

''(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

''(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860F(b).

''(B) USE OF STANDARDIZED TECHNOLOGY.—

''(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860F(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

''(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

''(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

''(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

''(ii) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(iii) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

''(iv) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(v) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860D(a).

''(2) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

''(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

''(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

''(iii) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

''(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(ii) ELEMENTS.—Such program may include—

''(I) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(III) detection of patterns of overuse and underuse of prescription drugs.

''(iii) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

''(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(C) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

''(ii) Subsection (c)(1) (relating to access to covered benefits).

''(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug covered under the plan that is therapeutically equivalent and bioequivalent.

''ANNUAL ENROLLMENT FEE

''SEC. 1860E. (a) AMOUNT.—

''(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment.

''(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

''(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

''(ii) such aggregate expenditures for the 12-month period ending with July 2005.

''(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

''(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

''(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

''(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

''BENEFITS UNDER THE PROGRAM

''SEC. 1860F. (a) ACCESS TO NEGOTIATED PRICES.—

''(1) NEGOTIATED PRICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term 'prescription drugs' is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

''(B) LIMITATIONS.—

''(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

''(2) DISCOUNT CARD.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

''(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

''(b) CATASTROPHIC BENEFIT.—

''(1) TEN PERCENT COST-SHARING.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

''(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

''(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as determined under section 1860I) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

''(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to $3,500.

''(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to $5,500.

''(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary's income for that year (rounded to the nearest multiple of $1).

''(3) APPLICATION.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

''(4) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year after 2006, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

''(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

''(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

''(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

''(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

''REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

''SEC. 1860G. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

''(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(c) ADMINISTRATIVE FEE BID.—

''(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

''(2) BID SUBMISSION REQUIREMENTS.—

''(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

''(i) Enrollment, including income eligibility determination.

''(ii) Claims processing.

''(iii) Quality assurance, including drug utilization review.

''(iv) Beneficiary and pharmacy customer service.

''(v) Coordination of benefits.

''(vi) Fraud and abuse prevention.

''(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

''(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

''(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

''(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

''(d) AWARDING OF CONTRACTS.—

''(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

''(2) TERMS AND CONDITIONS.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

''(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

''(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

''(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

''(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

''(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

''(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

''(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

''(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

''(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

''(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

''(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

''PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

''SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

''(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860F(b); and

''(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

''(b) PAYMENT FOR COVERED DRUGS.—

''(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860F(b).

''(2) LIMITATIONS.—

''(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(B).

''(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a) or the price negotiated for insurance coverage under the Medicare+Choice program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

''(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

''(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

''(c) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''DETERMINATION OF INCOME LEVELS

''SEC. 1860I. (a) DETERMINATION OF INCOME LEVELS.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E(c) and 1860F(b).

''(2) PROCEDURES.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

''(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

''(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E(c) and 1860F(b); and

''(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

''(c) QUALITY CONTROL SYSTEM.—

''(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

''(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

''APPROPRIATIONS

''SEC. 1860J. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E.

''MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

''SEC. 1860K. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the 'Board').

''(b) ADVICE ON POLICIES; REPORTS.—

''(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

''(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

''(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

''(A) PRESIDENTIAL APPOINTMENTS.—

''(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

''(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

''(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

''(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

''(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(3) COMPOSITION.—Of the members appointed under paragraph (1)—

''(A) at least 1 shall represent the pharmaceutical industry;

''(B) at least 1 shall represent physicians;

''(C) at least 1 shall represent medicare beneficiaries;

''(D) at least 1 shall represent practicing pharmacists; and

''(E) at least 1 shall represent eligible entities.

''(d) TERMS OF APPOINTMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

''(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

''(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

''(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

''(I) 2 years;

''(II) 4 years; and

''(III) 6 years.

''(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

''(I) 3 years; and

''(II) 6 years.

''(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

''(I) 4 years; and

''(II) 5 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

''(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

''(g) MEETINGS.—

''(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

''(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

''(i) PERSONNEL.—

''(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(2) STAFF.—

''(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

''(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 101).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part D.''.

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

''(1) PROMULGATION OF MODEL REGULATION.—

''(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of

Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

''(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

''(ii) a uniform format is used in the policy with respect to such revised benefits; and

''(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2006 NAIC Model Regulation').

''(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2006 Federal Regulation').

''(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

''(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

''(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

''(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

''(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

''(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

''(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.''.

SEC. __. PARTIAL FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR CATASTROPHIC COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1): is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(d)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

''(d) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

''(A) MEDICARE BENEFITS FOR MEDICAID ELIGIBLES.—The total amount of payments made in the quarter because of the operation of section 1845 that are attributable to individuals who are residents of the State and are eligible for medical assistance with respect to prescription drugs under this title.

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2005 is 90 percent;

''(B) a subsequent year before 2014, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

''(C) a year after 2013 is 0 percent.''.

(3) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(e) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to benefits under part B of title XVIII and is eligible for medical assistance with respect to prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under such part B, without regard to section 1902(n)(2).''.

(4) LIMITATION AND CAPS.—The Secretary will implement the above section to the extent possible within a total federal authorization of $35,000,000,000.

SEC. __. ADDITION OF DOLLAR AMOUNT TO PRESCRIPTION DRUG DISCOUNT CARDS; EFFECTIVE DATE.

(a) ADDITION OF DOLLAR AMOUNTS TO PRESCRIPTION DRUG DISCOUNT CARDS.—Section 1860F (as added by section 101) is amended by adding at the end the following:

''(c) PROVISION OF DOLLAR AMOUNTS ON CARDS.—

''(1) AMOUNT OF ANNUAL ASSISTANCE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, each eligible entity with a contract under this section shall provide coverage for the applicable amount of expenses for prescription drugs incurred during each calendar year by an eligible beneficiary enrolled in a prescription drug discount card plan offered by such entity.

''(B) APPLICABLE AMOUNT DEFINED.—For purposes of subparagraph (A), the term 'applicable amount' means the total amount that the Secretary determines will not cause expenditures under this part to exceed the total amount that would have been expended under this title if this part had not been enacted by more than $30,000,000,000 during the period beginning on January 1, 2005, and ending on September 30, 2010.

''(2) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible beneficiary is not enrolled in a prescription drug discount card plan offered by an eligible entity with a contract under this part, the amount of assistance available under paragraph (1) shall be reduced by $50.

''(3) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—

''(A) IN GENERAL.—The dollar amount of coverage described in paragraph (1) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

''(B) REFUND OF EXCESS AMOUNTS.—The Administrator shall refund to the eligible beneficiary the amount (if any) by which the dollar amount of coverage described in subparagraph (A) exceeds the catastrophic limit described in subsection (b).

''(4) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Administrator may waive such requirements of this part as may be necessary to ensure that each eligible beneficiary has access to the assistance described in subparagraph (A).

''(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card plan if the program excludes the drug under a formulary and such exclusion is not successfully resolved under the grievance or appeals processes provided for under this part.

''(6) PAYMENTS TO PLANS.—The Administrator shall reimburse each eligible entity for any costs incurred under this subsection.''.

(b) EFFECTIVE DATE.—Part D is amended by adding at the end the following new section:

''EFFECTIVE DATE

''Sec. 1860L. Nothwithstanding any other provision of this part, the Voluntary Medicare Prescription Drug Discount and Security Program under this part shall apply only during the period beginning on January 1, 2005 and ending on December 31, 2010.''.

Mr. HAGEL. Mr. President, I now ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. HAGEL. I thank the Chair and yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, the prescription drug bill, Medicare reform bill combination that we have before us today, as we all know, is a freight train coming through this place and there is no stopping it.

What is very unfortunate is that we have a very legitimate amendment on

the floor today that is getting 20, 30 minutes' worth of debate. I put up some examples on the chart here of how this amendment we are offering is superior. I have tried to be objective, to say that above 200 percent of poverty, between 200 and 400 percent of poverty they are pretty equal plans. For the very low income, our amendment is slightly less generous, but it keeps the low-income people with something at stake so they will shop. We have heard nothing about that from the other side. There has been no debate, in other words. It is because there is an agreement to defeat any substantive amendment. It is unfortunate.

This is probably the most important vote, as far as an entitlement program, that any of us in our careers will ever take, and this bill is being rushed through so that we can get a ''bill'' to conference, where all of the improvements are going to be made.

We have an amendment before us that I believe should be debated. If you disagree, fine, but let's debate it and vote on it up or down. But I don't think this kind of a process is healthy for the Senate.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Mr. BREAUX. Mr. President, I yield myself whatever time we have in opposition to the amendment.

The PRESIDING OFFICER. Of whose time?

Mr. BREAUX. Off of the chairman, Senator GRASSLEY's time.

The PRESIDING OFFICER. The Senator is recognized.

Mr. BREAUX. Mr. President, I start off by commending the authors of the amendment for a real serious effort to try to improve the bill. But I rise in opposition because there is not any segment of the senior population that you could not isolate and target and say we can make, for this particular group, a better deal than they have in this bill. That is not the purpose of this legislation.

The purpose of Medicare is that it is universal. It is not a welfare bill. It is not just for low-income individuals. It is for every American citizen who has reached the age of 65, or older, and qualifies for the program. That is one of the greatest features of the Medicare Program—that everyone is essentially treated equal.

So it is easy, if you want to isolate a low-income group and say we are going to give them a better deal. But when you are looking at the entire population of almost 40 million Americans with whom we have to deal, that, indeed, is the real challenge, and that is why the content of this bill is far superior than to narrowly isolate only low-income people and say we can do a better deal for them. Of course, but you are not going to be able to do that in keeping with the general theme of what Medicare is all about and taking care of all Medicare seniors with the best possible deal.

I think that is what the goal of this Congress should be, and that is why what we have in the provisions here to give them prescription drugs, which would be within the Medicare Program, that people can voluntarily continue to accept the traditional Medicare or, if they would like, move into an expanded Medicare Advantage and get all of the benefits through a private, competitively delivered system.

What we have is the beginning of a program that can be improved upon and will be. But we have essentially an insurance-type program, similar to what we have as Federal employees, which can be improved upon. But it is for everybody. We, too, give special attention to lower income individuals, and maybe they can do it better, but it is going to have to come from somewhere else, and the somewhere else is the vast number of other seniors who would have some of their benefits diluted and reduced in order to make this a little better than what is in this bill.

The goal is to try to create a universal program across the board, and one that is fair to everyone. I think that is what is in the bill as it now stands.

Mr. GREGG. Will the Senator yield for a question?

Mr. BREAUX. Yes, I am happy to yield.

Mr. GREGG. Would the Senator agree that there wasn't, in the original program set up as an insurance program, which you would pay into during your working life under the Part A part of the insurance program, with the concept that when you retired, you would have paid for your health insurance. That is why everyone is covered under it. But is it not also true that under this drug benefit as proposed, nobody will have paid into the Medicare insurance plan for the purposes of this drug program? This drug program will be a new entitlement, and therefore it is reasonable that since it is going to be borne not by the people who worked for it but by the people who are working—it is going to be borne by them rather than the recipients—then it should be set up in a different structure along the lines that are proposed, which is you benefit the low income and you benefit people who have a catastrophic event rather than have a program that puts the benefit out to everyone and forces 37 percent of the population off private insurance plans and on to a public plan.

Mr. BREAUX. I am not sure whose time this is on. I will respond to the Senator's question. We have a health delivery system supervised by the Federal Government, and the beneficiaries are going to contribute to it. Those benefiting from it are going to have an average premium of $35 a month, a $275 deductible, and 50 percent copayment.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. BREAUX. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Parliamentary inquiry: Will the Chair inform the Senate as to the time allowable on this amendment?

The PRESIDING OFFICER. The Senator from Nebraska has 4 minutes 30 seconds remaining. No time remains in opposition.

Mr. BAUCUS. I wonder if I can get consent to speak for 1 minute on this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, two points: One, this amendment is totally new. We have not seen the language. We have been asking for the language for days. It has been filed in various forms. This is new language. The Senate has no idea what is in this amendment. We saw it for the first time maybe 15, 20, 30 minutes ago. It is impossible to know what this amendment does.

Point No. 2, essentially what we can tell by a cursory glance at the amendment is the amendment enters a whole new concept in Medicare that has not been done before, and that is means testing. It means tests those at the catastrophic levels.

I do not think we want to begin to go down that road tonight. It makes more sense to stay with the underlying bill which essentially gives a 44-percent rate to those beneficiaries with lower income.

The problem is it does not help, as our bill does, up to catastrophic, and then catastrophic is means tested. That is not the right thing to do, certainly at this hour after looking at it 30 minutes ago.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Nevada.

Mr. ENSIGN. Mr. President, I ask unanimous consent for whatever time I consume from Senator HAGEL's time to respond.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HAGEL. Mr. President, I understand I have 4 minutes 20 seconds.

The PRESIDING OFFICER. That is correct.

Mr. HAGEL. I yield to my colleague whatever time he requires from my time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENSIGN. Mr. President, means testing and universal have been mentioned. The Senator from New Hampshire mentioned that this is a brand new benefit, and that is why we are only talking about the prescription drug part—a brand new benefit for which young people in America are going to be paying for years and years. It seems to make sense that we try to control those costs.

Yes, our bill means tests. So does the underlying bill. To sit up here and say their bill does not means test is completely disingenuous. They have several levels in the low-income areas they means test. They are just means testing in a different area. If you

means test one, why is calling our bill means testing when their bill means tests as well? How can they say our bill means tests and theirs does not? That is disingenuous.

It is critical that we have this debate. There was a complaint that they just saw this amendment tonight. Part of the reason is that we are trying to rush this bill through what is supposed to be the most deliberative body in the world, and we have this false deadline that we must get this bill passed before the July break. I submit, this deserves more debate. The debate cannot happen when it goes to conference because most of the Senate is cut out then and there is no debate when it comes back here.

With all due respect, I think we have a superior portion of the prescription drug plan, and I hope our colleagues vote for this plan.

I reserve the remainder of our time.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. HAGEL. Mr. President, how much time is remaining?

The PRESIDING OFFICER. Two and a half minutes.

Mr. HAGEL. Mr. President, in addition to what my colleague from Nevada has said in response to the distinguished Senator from Montana, there is nothing new about this bill except two features.

This bill, the Hagel-Ensign bill, last year received more bipartisan votes on the floor of this Senate than any other bill. There is nothing new in this bill except two features. One is the $30 billion for low-income seniors' additional coverage, and the other is the $35 billion in cost sharing for catastrophic drug costs with Medicare and Medicaid to dual eligibles. That is what is new in the bill.

To say this is new and we have just sprung this on the Senate is a bit disingenuous. This bill has been around for almost 4 years in its current form.

I yield the floor.

The PRESIDING OFFICER. Does the Senator yield back his time?

Mr. HAGEL. Mr. President, I yield back all of my time.

AMENDMENT NO. 1111

The PRESIDING OFFICER. There are 2 minutes evenly divided on the Levin amendment No. 1111. Who yields time on the Levin amendment No. 1111?

Mr. BAUCUS. It is my understanding the sponsor, Senator LEVIN, is in the Chamber.

Mr. LEVIN. I have already spoken on the amendment.

The PRESIDING OFFICER (Mr. ENSIGN). All time is yielded back.

The question is on agreeing to amendment No. 1111.

Mr. BAUCUS. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Oklahoma (Mr. INHOFE) are necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea.''

The PRESIDING OFFICER (Mr. GREGG). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 42, nays 54, as follows:

[Rollcall Vote No. 259 Leg.]

YEAS—42

Akaka	Durbin	Levin
Bayh	Edwards	Lincoln
Biden	Feingold	Mikulski
Bingaman	Feinstein	Murray
Boxer	Graham (FL)	Nelson (FL)
Byrd	Harkin	Nelson (NE)
Cantwell	Hollings	Pryor
Clinton	Inouye	Reed
Conrad	Johnson	Reid
Corzine	Kennedy	Rockefeller
Daschle	Kohl	Sarbanes
Dayton	Landrieu	Schumer
Dodd	Lautenberg	Stabenow
Dorgan	Leahy	Wyden

NAYS—54

Alexander	Craig	McCain
Allard	Crapo	McConnell
Allen	DeWine	Miller
Baucus	Dole	Murkowski
Bennett	Ensign	Nickles
Bond	Enzi	Roberts
Breaux	Fitzgerald	Santorum
Brownback	Frist	Sessions
Bunning	Graham (SC)	Shelby
Burns	Grassley	Smith
Campbell	Gregg	Snowe
Carper	Hagel	Specter
Chafee	Hatch	Stevens
Chambliss	Hutchison	Sununu
Cochran	Jeffords	Talent
Coleman	Kyl	Thomas
Collins	Lott	Voinovich
Cornyn	Lugar	Warner

NOT VOTING—4

Domenici	Kerry
Inhofe	Lieberman

The amendment (No. 1111) was rejected.

Mr. LOTT. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1026, AS MODIFIED

The PRESIDING OFFICER. Before we can go to the next amendment, we will have to have order in the Senate.

There are 2 minutes equally divided. Who seeks recognition? The Senator from Nevada.

Mr. ENSIGN. Mr. President, I will use 30 seconds and Senator HAGEL will use 30 seconds on this side.

The Hagel-Ensign amendment corrects several problems in the bill. Let me go over those real briefly.

We have no monthly premiums. We do not make middle-class taxpayers pay for prescription drugs for wealthy seniors. We preserve the State and the private plans that are already out there, which the underlying bill does not do. We give most of our help to low- and moderate-income seniors but we still control costs in our bill.

I encourage a ''yes'' vote on this amendment.

Mr. HAGEL. Mr. President, to summarize our amendment is simple: It helps those who need it most. It helps the States provide a discount drug card. It is affordable, with no monthly premiums, no deductibles, catastrophic coverage, and accountable market-based tools. It is a complete, affordable, discount drug plan that the next generation of this country can support. We can be proud of what we are doing for our seniors.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the major fatal problem with this amendment is it dispenses with the underlying principle of the underlying bill. That is universality. We are, in the legislation before us, providing for universal benefits.

This amendment violates that principle by saying no, not across the board for Americans but, rather, it introduces a whole new means testing provision for catastrophic. I just think it fatally violates the spirit of the legislation we are about to pass.

The PRESIDING OFFICER. All time has expired. The question is on agreeing the amendment No. 1026, as modified. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Oklahoma (Mr. INHOFE) are necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 21, nays 75, as follows:

[Rollcall Vote No. 260 Leg.]

YEAS—21

Allard	Graham (SC)	McConnell
Brownback	Gregg	Reid
Burns	Hagel	Roberts
Chambliss	Hutchison	Santorum
Crapo	Lott	Sessions
Dole	Lugar	Sununu
Ensign	McCain	Talent

NAYS—75

Akaka	Chafee	Enzi
Alexander	Clinton	Feingold
Allen	Cochran	Feinstein
Baucus	Coleman	Fitzgerald
Bayh	Collins	Frist
Bennett	Conrad	Graham (FL)
Biden	Cornyn	Grassley
Bingaman	Corzine	Harkin
Bond	Craig	Hatch
Boxer	Daschle	Hollings
Breaux	Dayton	Inouye
Bunning	DeWine	Jeffords
Byrd	Dodd	Johnson
Campbell	Dorgan	Kennedy
Cantwell	Durbin	Kohl
Carper	Edwards	Kyl

Landrieu	Nelson (FL)	Smith
Lautenberg	Nelson (NE)	Snowe
Leahy	Nickles	Specter
Levin	Pryor	Stabenow
Lincoln	Reed	Stevens
Mikulski	Rockefeller	Thomas
Miller	Sarbanes	Voinovich
Murkowski	Schumer	Warner
Murray	Shelby	Wyden

NOT VOTING—4

Domenici	Kerry
Inhofe	Lieberman

The amendment (No. 1026), as modified, was rejected.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, for the information of Senators, we have made tremendous progress today, and we are on the final leg. In conversations with the managers, it appears we will have one more series of stacked votes tonight and that will include final passage. That series will be it. The bill will be done.

We need somewhere between 45 minutes and an hour—hopefully 45 minutes, and hopefully people can yield back their time—before we can begin those votes. I think that is all we can say at this juncture, working in good faith. There are a lot of details. We are waiting for some of the final wording to come through in terms of the managers' package. Once we have that, we will be able to proceed with the voting.

I don't know how many amendments it will be. It could be two amendments; it could be four amendments; it could be one amendment or passage. But it is going to be probably two or four amendments beginning in about 45 minutes to an hour.

Mr. BYRD. Will the leader yield?

Mr. FRIST. Yes.

Mr. BYRD. On the preceding rollcall vote, 28 minutes were required. On this rollcall vote, 22 or 23 minutes were required. So we have over 50 minutes on two rollcall votes. Now, time is worth a little something around here to many of us who don't have much time left. I wonder if we can't do better than that.

I think the Senate ought to treat itself better than that. Senators owe to it other Senators to not just lag and cause rollcall votes to last so long. Twenty-eight minutes on a rollcall vote? Why can't we go over to tomorrow? We are going to be here anyhow. Why can't we go over? Here it is 15 minutes after 10. Do I have the floor, Mr. President?

The PRESIDING OFFICER. The majority leader has the floor.

Mr. BYRD. Very well.

Mr. FRIST. Mr. President, we can do better, and I think we ought to do our best to try to do maybe 10 minutes on the last series. It is late at night. We have all been working about 12, 13 hours nonstop. It is an important bill. We set out this morning to finish tonight. People are here. They are ready to finish it. It is late. After talking to the managers and the leadership on both sides, there is a general consensus that we ought to push ahead, get this bill done for the American people.

We can do it. Things have gone very well. We have had adequate time for debate and amendment. The distinguished Senator from West Virginia told me from day one: My advice to you as the majority leader is to make sure you give time for debate and amendment. He did forget to tell me that it is sometimes hard dealing back and forth as you are waiting for language to come, as you are trying to get the order for amendments in these last hours on a very complex bill, a bill that is as big as any bill we have passed this year and as complex, and it has taken a little bit more time.

I would have liked to have finished at 9 o'clock tonight. I think at this juncture, if we proceed over the next 45 minutes—let's do those rollcall votes in 10 minutes—we will be out of here. People will be able to leave tomorrow or stay and come to the floor and talk. I think that is the general sense of where we should go.

Mr. BYRD. Mr. President, will the Senator yield?

Mr. FRIST. The Senator is happy to yield to the Senator from West Virginia.

Mr. BYRD. Mr. President, we are falling into this way of doing things. Three-day work weeks. I will tell you, Mr. Leader, one night I am going to get the floor and Senators will be planning on finishing and going home the next day. They won't get to do that. I have seen this happening over and over and over more recently. Three-day work weeks, and we don't come in on Friday and work and vote.

If the Senator will continue to yield, just briefly?

Mr. FRIST. If the Senator will yield for a couple more minutes because we do have people who want to get on to the business. I certainly do yield for a few more minutes.

Mr. BYRD. Mr. President, I don't want to overtax the leader at this point or overtax other Senators. Just suffice it to say, we had better get out of this habit of just having 3-day workweeks, staying here until 10, 11, 12 on Thursday night so that people can go out on Friday. I started this thing of having a week at home every 4 weeks, but we worked the 5 days. We worked 5 days in each of the 3 weeks in between, and we started voting early on Mondays and we voted a full day on Friday. I know things have changed. I am not majority leader. I don't mean to be a problem to the majority leader. But this is getting to be a problem with some of us.

Mr. FRIST. Mr. President, let me just reply and say: Last Friday, you and I were on the floor at 3 in the afternoon. Just because we are not voting doesn't mean we are not working. Some of us do have constituents we go back to and spend time with. Some of us are working on bills and reading. Just because we are not voting does not mean we are not working.

Mr. BYRD. I understand that.

Mr. FRIST. Again, I suggest that we go back so we can work and debate and get these two or four amendments finished. I would be happy to talk to the Senator. I understand he wants us to be efficient and work 5 days a week. I would like to work 6 days a week.

Mr. BYRD. I have a wife at home and she needs me there. I ought to be there. I have stopped early on two occasions lately just to go be with her and let the Senate run its course. There is going to come a time when this Senator is going to keep the Senate in session a while. He can still do it.

I say this in the very best of spirit to the leader—and he is doing the best he can—there comes a time when some of us have duties elsewhere and we would like to keep our rollcall records clean. Soon I will have cast 17,000 rollcall votes. So I have been here for my share of the votes. I am getting a little bit fed up staying around here. This last rollcall vote was 23 minutes and the one before that was 28 minutes. There is a lot of hooping and hollering. What do the American people think of us? It is time we went home if we don't work.

I hope, Mr. Leader, that those of you who are so good at working out these things can get people to have voice votes or maybe cut down the time on their amendments.

Mr. FRIST. Mr. President, I suggest that, since we have our colleagues here and ready to work, we go back to work now. I think the Senator made his point. I am listening and I will heed that advice and counsel. I suggest we go back to work so we can get home tonight to our families as well.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition? The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I believe we are in the process of trying to wrap up debate on a few amendments. I believe momentarily Senator FEINSTEIN and Senator CHAFEE and I will be discussing our amendment. I will make my comments very brief. I know Senator FEINSTEIN wishes to speak on it. I hope we can conclude debate. I think there will only be two more amendments. I urge colleagues to make their comments brief and let's vote and finish action on this bill. I will defer my comments on the amendment because I believe the Senator from California is ready to speak.

The PRESIDING OFFICER. The Senator from California is recognized.

AMENDMENT NO. 1060, AS MODIFIED

Mrs. FEINSTEIN. Mr. President, I call up amendment No. 1060, as modified.

The PRESIDING OFFICER. Without objection, the amendment, as modified, is now the pending business.

The amendment (No. 1060), as modified, is as follows:

At the end of title IV, insert:

Subtitle D—Part B Premium

SEC. ___. INCOME-RELATED INCREASE IN MEDICARE PART B PREMIUM.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

''(h) INCREASE IN PREMIUM FOR HIGH-INCOME BENEFICIARIES.—

''(1) AMOUNT OF INCREASE.—

''(A) IN GENERAL.—Except as provided in paragraph (4), if the modified adjusted gross income of an individual for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) exceeds the threshold amount, the amount of the premium under subsection (a) for the individual for the calendar year shall, in lieu of the amount otherwise determined under subsection (a), be equal to the applicable percentage of an amount equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for the calendar year.

''(B) APPLICABLE PERCENTAGE.—The term 'applicable percentage' means the percentage determined in accordance with the following tables:

''(i) INDIVIDUALS NOT FILING JOINT RETURNS.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $50,000	50 percent
More than $50,000 but not more than $100,000	75 percent
More than $100,000	100 percent.

''(ii) INDIVIDUALS FILING JOINT RETURNS.—

"If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than $100,000	50 percent
More than $100,000 but not more than $200,000	75 percent
More than $200,000	100 percent.

''(C) DEFINITION OF THRESHOLD AMOUNT.—For purposes of this subsection, the term 'threshold amount' means—

''(i) except as provided in clause (ii), $100,000; and

''(ii) $200,000 in the case of a taxpayer filing a joint return.

''(D) INFLATION ADJUSTMENT FOR THRESHOLD AMOUNT.—

''(i) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in clause (i) of subparagraph (C) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding calendar year exceeds such average for the 12-month period ending with June 2005.

''(ii) JOINT RETURNS.—The dollar amount described in clause (ii) of subparagraph (C) for any calendar year after 2006 shall be increased to an amount equal to twice the amount in effect under clause (i) of subparagraph (C) (after application of this subparagraph).

''(iii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

''(E) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(F) JOINT RETURN.—For purposes of this subsection, the term 'joint return' has the meaning given such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

''(2) DETERMINATION OF MODIFIED ADJUSTED GROSS INCOME.—The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) NOTICE.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year. In providing such notice, the Secretary shall use the most recent poverty line available as of the date the notice is sent.

''(B) CALCULATION BASED ON INFORMATION PROVIDED BY BENEFICIARY.—If, during the 60-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with appropriate information (as determined by the Secretary) on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) CALCULATION BASED ON NOTICE AMOUNT IF NO INFORMATION IS PROVIDED BY THE BENEFICIARY OR IF THE SECRETARY DETERMINES THAT THE PROVIDED INFORMATION IN NOT APPROPRIATE.—The amount initially determined by the Secretary under this paragraph with respect to an individual shall be the amount included in the notice provided to the individual under subparagraph (A) if—

''(i) the individual does not provide the Secretary with information under subparagraph (B); or

''(ii) the Secretary determines that the information provided by the individual to the Secretary under such subparagraph in not appropriate.

''(3) ADJUSTMENTS.—

''(A) IN GENERAL.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (2), the Secretary shall increase or decrease the amount of the individual's monthly premium under this part (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this part during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (2) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B) INTEREST.—

''(i) INCREASE.—In the case of an individual for whom the amount initially determined by the Secretary under paragraph (2) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual's actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (2), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by an amount of interest equal to the sum of the amounts determined under clause (ii) for each of the months described in such clause.

''(ii) COMPUTATION.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (2) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (2) and ending 30 days before the first month for which the individual's monthly premium is increased under this paragraph.

''(iii) EXCEPTION.—Interest shall not be imposed under this subparagraph if the amount of the individual's modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (2) was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

''(C) STEPS TO RECOVER AMOUNTS DUE FROM PREVIOUSLY ENROLLED BENEFICIARIES.—In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this part for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium under this part for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(D) DECEASED BENEFICIARY.—In the case of a deceased individual for whom the amount of the monthly premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(4) WAIVER BY SECRETARY.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

''(5) TRANSFER TO PART B TRUST FUND.—

''(A) IN GENERAL.—The Secretary shall transfer amounts received pursuant to this subsection to the Federal Supplementary Medical Insurance Trust Fund.

''(B) DISREGARD.—In applying section 1844(a), amounts attributable to subparagraph (A) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B) thereof.''

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting ''or section subsection (h)'' after ''subsections (b) and (e)'';

(B) in subsection (a)(3) of section 1839(a), by inserting ''or subsection (h)'' after ''subsection (e)'';

(C) in subsection (b), inserting ''(and as increased under subsection (h))'' after ''subsection (a) or (e)''; and

(D) in subsection (f), by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting ''or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted,'' before ''he may''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(19) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Centers for Medicare & Medicaid Services return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3)(A) of section 6103(p) of such Code is amended by striking ''or (18)'' each place it appears and inserting ''(18), or (19)''.

(B) Paragraph (4) of section 6103(p) of such Code is amended by striking ''or (16)'' and inserting ''(16), or (19)''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 2006.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(19) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 2002.

Mrs. FEINSTEIN. Mr. President, this amendment is presented on behalf of myself, Senators NICKLES, CHAFEE, LINDSEY GRAHAM, ALEXANDER, and MCCAIN.

This amendment provides that Medicare beneficiaries with an annual adjusted gross income of over $200,000, or above, pay the full cost of the Medicare Part B premium. The amendment uses a sliding scale to ramp up the beneficiary's share of the Part B premium.

The amendment we are offering would hold Medicare beneficiaries with annual adjusted gross incomes between $100,000 and $150,000 a year responsible for 50 percent of the cost of the premium. In 2003, this amounts to $116.40 a month, or $1,396 annually, rather than $58.20 monthly, or $698 annually, which is what the beneficiary pays today for the benefit.

Medicare beneficiaries with incomes between $150,000 a year and $200,000 a year—that is $300,000 to $400,000 for a couple—would be responsible for 75 percent of the total cost of the Part B premium. In 2003, this amounts to $174 or $2,095 annually.

Medicare beneficiaries with annual incomes above $200,000—that is $400,000 for couples—would be responsible for 100 percent of the total cost of the premium. In 2003, this amounts to $232.80 a month, or $2,793 annually. Now, for a beneficiary with an annual income of $200,000, this amounts to less than 1.4 percent of their annual income. For the vast majority of Medicare beneficiaries, some 37 million of the 38 million beneficiaries, Part B premiums would remain the same as they are today.

According to the Census Bureau, about 98 percent of all Medicare beneficiaries have annual incomes below $100,000. So the amendment we are proposing will affect about 2 percent of the most affluent and well off Medicare beneficiaries.

Let me be clear. This amendment does not deprive any Medicare beneficiary of any benefit. What this amendment says is that if you can afford to pay the price for the Medicare Part B premium, you should. Those Medicare beneficiaries who have annual incomes below $100,000 a year will still be able to receive a 75-percent Government subsidy for their premium.

Now, I strongly believe the time has come to begin to income-relate some of these benefits. The Federal Government should not be subsidizing the Part B premiums of those beneficiaries who can afford to pay for the cost of the premiums themselves.

Much has changed since the creation of Medicare in 1965. People are living longer, due in large part to improved diagnostic tools and treatment. There is no way Congress could have predicted the number of people who would come to rely on Medicare or the rate at which medical expenses would grow. When Medicare was established in 1965, the Part B premium was set at a level to cover about 50 percent of program costs. With medical inflation, the dollar amount of the premium has declined to cover only 25 percent of program costs.

The Omnibus Budget Reconciliation Act of 1993 established the Medicare Part B premium to equal 25 percent of the program cost from 1996 to 1998. The Balanced Budget Act of 1997 permanently established the Part B premium at 25 percent. The bill to balance the budget in 1997 that passed out of the Senate Finance Committee included a provision to income relate the Medicare Part B premium. So this is nothing new.

The provision included in 1997 would have had beneficiaries with incomes over $50,000 for an individual and $75,000 for a couple paying a greater share of the premium. This provision was stripped out during conference.

Well, we were in a different financial situation when Congress made the decision to set the beneficiary's share of the Part B premium at 25 percent in 1997. At that time, we had only a $22 billion deficit. The next year the budget was in surplus to the tune of $69 billion.

With a Federal budget deficit of over $400 billion in the year 2003 and an increase in the Federal debt of $5.3 trillion, for a total of $12 trillion in debt expected by 2013, I believe that now is the time to rethink the premium structure of Medicare Part B.

As the baby boomers age, there will be an increasing reliance on and demand for the Medicare Program.

The number of people age 65 and older will more than double over the coming decades, rising from 37 million today to 70 million in 2030 and 82 million in 2050. Over the next 75 years, the Medicare program will cost 71 percent more than that provided under current law in order to meet its needs.

It is predicted the Medicare hospital trust fund will be insolvent by 2030. The CBO projects Medicare spending will nearly quadruple by 2075 in order to meet the growing need for the program, with budget outlays of $277 billion in 2003. This means spending for the program could reach $1.1 trillion by 2075.

With the legislation currently before the Senate, Congress is proposing some major changes to the Medicare Program. I am in full support of adding a drug benefit, but Congress should also rethink the financing mechanisms of the program, and this bill is short in that direction. High-income beneficiaries can afford to pay a larger share of Medicare's costs, at least of

the premium. They can afford to pay for the benefits they receive.

In light of the fact the Federal Government has just provided tax cuts in the range of $1,841 for people with incomes between $77,000 and $154,000 and up to $30,000 for people with incomes above $374,000, it seems to me people with annual incomes above $200,000 can afford to pay $2,793, which is the annual premium for Medicare Part B this year.

We should focus funding so that 98 percent of Medicare beneficiaries who have an annual adjusted gross income of less than $100,000 can continue to access benefits. I think it is reasonable to ask those who can afford it to pay a greater share of the premium. We are still waiting for an official cost savings score from CBO, but I believe this amendment could save billions of dollars.

Once again, Mr. President, this amendment affects less than 2 percent and only those with incomes of more than $200,000 a year adjusted gross income would pay the full premium of about $2,900 a year. We think this is a reasonable proposal. It is scaled up. It impacts no one below $100,000 adjusted gross income a year, and at the maximum for people of over $200,000 a year in adjusted gross income, the premium would be just $2,900.

The income limits would be indexed to medical inflation and, according to current population survey data from 2002, only 2 percent, or about 1 million people of the 38 million Medicare beneficiaries, have incomes of over $100,000 a year. This would protect the tax subsidy for people who need it by encouraging those who have the dollars simply to pay either a greater share of the premium cost or the full premium cost.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I join with Senator FEINSTEIN, Senator NICKLES, and others in presenting this amendment this evening. I believe this income-related Part B premium for only the wealthiest of seniors, a little over 1 percent of the entire Medicare population, is necessary to sustain the long-term solvency of the Medicare Program.

I wish to make just three points on this issue. First, as Senator FEINSTEIN has said, previous Congresses have worked on this issue. In 1997, the Senate voted 70 to 30 to do exactly what we are doing here, and most of those Senators are still here today.

Second, many of these seniors can afford this added premium. Most seniors, it is safe to say, who are making over $100,000 a year have already paid off their mortgages. They have paid off their loans. They have educated their children. They can afford these higher premiums which would go from only $1,400 a year to $2,800 a year, at the most, depending on the income they make. So seniors who are making $100,000 at the most will pay only $1,400 a year, and those making $200,000 will pay $2,800 a year. I do not think that is too much to ask to help keep this program solvent.

Finally, if we do not do this today, some other Congress is going to do it. In 1997, the National Bipartisan Commission on the Future of Medicare was created to resolve the long-term insolvency facing the system. That was in 1997 and it was known as the Breaux-Frist Commission. They did not report their work to Congress. They fell short of the votes necessary to report their work to Congress.

However, it is interesting to note that one of the reasons they failed to get the votes to report to Congress was the President at the time, President Clinton, called for putting aside 15 percent of budget surpluses the next 15 years to pay down the debt and to shore up Medicare. Fifteen years of budget surpluses—when will we see those again?—to shore up Medicare. Because the Breaux-Frist plan did not include that, they did not get the votes necessary.

Mr. President, now is the time to adopt this amendment. If we do not adopt it, future Congresses will have to wrestle with this dilemma.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, for the information of our colleagues, I am going to make a couple comments on this amendment. There may be an amendment by the Senator from Pennsylvania that will require a vote on or in relation to Senator CORZINE's amendment. I think we are close to finishing. I hope we can. I just make those comments.

I compliment Senator FEINSTEIN and also Senator CHAFEE, Senator ALEXANDER, Senator MCCAIN, and others for supporting this amendment. Senator CHAFEE mentioned we passed the income-related Part B premium several years ago with 70 votes. I believe the majority of people, a strong majority—looking at the people who voted for it—are still here. I hope we vote for it again.

Medicare has some big problems long term. The bill before us has a lot of new subsidies but does not have a lot of reform to make it affordable for future generations.

Part B right now is subsidized by general revenues 3 to 1 Federal Government and individuals. The amendment before us on Part B says if individuals have income above $100,000, they should pay at least 50 percent. If they have income above $200,000, they should pay it all. For couples, that would be $400,000. A couple could make $400,000 before they pay all their Part B premium.

Surely we can do that. Why should we ask our kids and/or our grandkids, who might have incomes of $20,000 or $30,000, to be subsidizing individuals to that degree?

I compliment my colleagues for this amendment. I will read from the annual report of the board of trustees of the HI trust fund. It says:

> Similarly, SMI general revenues in the year 2002 were equivalent to about 7.8 percent of personal and corporate Federal income tax collected in that year. If such tax is to remain at the current level relative to the national economy, then SMI—

That is Part B—

> general revenue financing in 2077 would represent roughly 32 percent of total income taxes.

That is almost one-third of total income taxes. That is not affordable. That is not sustainable. So I think the amendment we have before us by Senator FEINSTEIN and Senator CHAFEE and others is a small step in the right direction to try to make this system more affordable for future generations.

I compliment my colleagues for this amendment. I urge our colleagues to support this small step toward reform.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

IN REMEMBRANCE OF STROM THURMOND

Mr. FRIST. Mr. President, a few moments ago we were made aware that at 9:45 tonight a close friend, a confidant, a colleague to most of us in this body, Strom Thurmond, passed away.

It was a century ago when Mark Twain was alive and Teddy Roosevelt was President that James Strom Thurmond was born in South Carolina and at that time began a life unmatched in public service. Just about all of us in this body have had the real privilege of serving alongside Strom Thurmond. A long-time friend of Senator Thurmond, Hortense Woodson, once said of him:

> Everything he's done has been done in the full. There's no halfway doings about Strom.

Indeed, Strom Thurmond will forever be a symbol of what one person can accomplish when they live life, as we all know he did, to the fullest. To his family and his friends, we offer our sincerest sympathies.

It was unexpected that he would die this evening while we are in the middle of completing a very historic bill, and it would be clearly appropriate for us to make recognition of his passing for a moment now, with plans, either after completion of the bill tonight or tomorrow, for people to make more extended statements.

Again, we extend to his family our deepest sympathies and our continued prayers.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I join with the majority leader in expressing